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ABSTRACT

This report presents the results of an evaluation of New York State's Mental Health Information Services (MHISs). The goals of the evaluation were to determine the effectiveness with which legislatively mandated information services to the mentally disabled and to the courts were carried out, and to evaluate MHIS workload and activity in order to assess their request for staffing increases. Following an executive summary, the introduction provides background information on the establishment of the four MHISs, and details the services they are required to provide, including those explicitly mandated and those which implicitly flow from the law. Chapter II describes the procedures used to evaluate the program's effectiveness, and provides a discussion of the results accompanied by 11 data tables. Chapter III reviews the program operation of the four MHISs, analyzes prior measures of MHIS workload, and presents the legislative committee's own survey of MHIS workload. Chapter summaries are provided for each area. The appendices include a list of those interviewed and contacted for the evaluation, samples of MHIS files used in the evaluation, classifications of sections of the law mandating or permitting information services, the MHIS workload form, and copies of the correspondence between the agencies involved in the evaluation and the legislative committee (responses and rebuttal). (MCF)

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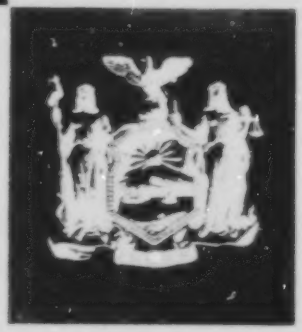


Program Audit
May 1984

SUMMARY AND CONCLUSIONS

The New York State Mental Health Information Services (MHISs) exist to ensure that constitutional protections against wrongful deprivation of liberty are provided to persons admitted to facilities for the mentally disabled. The MHISs help to preserve the balance between the patient and his family and the interests and obligations of society. To do so, they carry out a variety of responsibilities defined in legislation including:

--Oversight and review of admissions and retentions;

--Informing patients and their families of the patients' rights;

--Submitting "background" reports to judges hearing cases involving patients, with information pertinent to the case (similar to a probation report);

--Investigating allegations of patient abuse and mistreatment;

--Taking legal action to protect patients against abuse and mistreatment;

--Representing patients in judicial hearings growing out of abuse and mistreatment, when the patient is unable to obtain his own counsel;

--Fulfilling the requirements of a judge to provide (unspecified) services and assistance to patients, their families and the courts, according to the regulations of the presiding justice of the appellate division of the supreme court.

The workload and activity of the MHISs are defined by both legislative and administrative mandates. The legislative mandates are in those sections of law which place clear obligations on the MHISs requiring them to act. The administrative mandates are those which come from the administrative rules and regulations promulgated by the presiding justice and are not found directly stated in legislation. The presiding justices' authority to promulgate such rules and regulations comes from the Mental Hygiene Law. The purposes of this audit were to:

1. Evaluate the effectiveness with which legislatively mandated information services to the mentally disabled and the courts were carried out, and

2. Provide the Legislature with an evaluation of workload and activity to be used in assessing the MHISs requests for staffing increases.

The MHISs were created by legislation in 1964 which restructured the procedures for the admission and retention of involuntary psychiatric patients (the scope of the population to be served has since been expanded), and they began operation in September, 1965. MHISs were placed in the judiciary to guarantee their independence and freedom from interference. The MHISs fit into the existing administrative structure of four judicial departments which comprise the Appellate Division of the Supreme Court. The presiding justice of each judicial department heads the MHIS in that depart-

ment, with day-to-day operation of the agency the responsibility of a director appointed by the presiding justice.

Provision of Mandated Protections

The LCER search of randomly selected files at each of the four judicial department MHISs revealed that they are not effective in providing legislatively mandated services to patients and the courts. A review of each admission is required to guarantee that all due process protections have been provided. When all categories of cases within a department--involuntary/voluntary/informal and non-objecting--had been aggregated, the admissions reviewed ranged from a high of 28 percent in the Second Department MHIS to a low of nine percent in the Third Department MHIS. When the data were analyzed by category of admission status it was found that the MHISs were most effective at reviewing involuntary status admissions. The Second Department achieved the highest rate--55 percent reviewed--and the Fourth Department had the lowest percentage of involuntary admissions reviewed--25 percent. That means that between 45 percent (in the Second department) and 75 percent (in the Fourth Department) of involuntarily admitted patients did not receive the protection of MHIS review. The admissions of voluntary status patients were rarely reviewed. Within the four MHISs between zero and 22 percent of the voluntary status patients were reviewed. Patients on non-objecting status admitted to facilities for the mentally retarded/developmentally disabled are, perhaps, in greatest need of the MHISs' watchful protection--they are not getting it. Between zero and 36 percent of non-objecting admissions were reviewed, among the four judicial department MHISs.

The MHISs are also legislatively mandated to provide notice to each and every patient and/or his family of the proper admission procedure and of his legal rights to judicial hearing and review, representation by counsel and independent medical opinion. In all four MHISs less than one-third of the eligible patient case files in the sample showed evidence that such notice had been provided by MHIS staff. Among patients on involuntary status between 50 and 87 percent of sample cases did not receive services. Patients on involuntary status were those cited by the MHIS directors as most in need of notice of rights, because they are held without their consent.

The four MHISs were most successful in conducting reviews of involuntary retentions. In the Third Department MHIS 73 percent of the sample cases fell in the category "all retentions reviewed." In the Second and Fourth Departments the rates achieved were 92 and 93 percent, respectively. First Department data are skewed by its having Bellevue Hospital as its responsibility. Bellevue has a high proportion of emergency admissions. The medical staff routinely apply to the court for orders of involuntary retention for each of these patients. However, many are released by the facility before the retention hearing is held. Because the figures are artificially inflated they portray a more negative picture than is the case. Therefore, only one-third of First Department cases had all retention reviews completed.

The MHISs are responsible for conducting annual reviews of the suitability (defined in law) and willingness of voluntary, informal, non-objecting and conditionally released patients to remain on those statuses. In the Second Department only 13 percent of the cases were in the "cases with no reviews completed" category. The proportion of cases which fell in that category, in the other three departments were: 36 percent in the Third Department, 41 percent in the First Department and 61 percent in the Fourth Department.

None of the four MHISs made as effective a use of incident report review to detect patterns of abuse and mistreatment as they might have because the rates achieved of "cases with all reviews completed" ranged from a low of eight percent in the Third Department to a high of 49 percent in the Fourth Department.

MHISs' Services to the Courts

The MHISs are mandated by law to provide information reports to the courts. The reports are to contain information intended to help the judge in carrying out the court's responsibilities--without regard to whether the background information about the patient (his case, his hospitalization, right to discharge, etc.) would support or contradict the patient's legal case. When it was suggested by critics--the Commission On Quality of Care For the Mentally Disabled, for example--that the submission of neutral information reports (a legislative mandate) conflicted with direct legal representation (an administrative mandate, except in certain abuse cases) it was the law which gave ground. The MHISs continue direct legal representation and the information report has been transformed into a memorandum of law. The memorandum of law is submitted as part of the patient's legal brief and contains only information which does not contradict the patient's case.

The LCER survey of judges to determine their opinions of the "information reports" and the MHISs themselves received overwhelmingly favorable responses overall. The judges responding to the survey stated that: the MHISs do provide the courts with "information reports" containing non-partisan information about the patients' cases; the reports are useful, timely, have adequate content and provide appropriate data; and, the MHISs' adversaries in judicial proceedings represented the State's interests adequately.

The individual comments made by some of the judges added depth to their responses:

--The reports give an excellent synopsis of pertinent information;

--The reports are detailed and thorough and informative in assisting the court;

--They are valued by court, sufficient data on which to base a decision; and

--They are balanced and addressed the relevant facts.

However, there were a few negative comments, that the reports were:

--So generalized as to be inadequate;

--Not sufficiently personalized;

--[Omitting] information adverse to patient release;

--All identical and of no value to the court;

--[In some cases] biased.

Because of the change in the nature of the reports being submitted to the courts, one judge commented "now as the advocate of the patient the MHIS views the judge as an adversary. The court has lost its independent 'eyes and ears'."

Adversarial Relationship Between MHISs and State Agencies

NYS Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD) facility directors were surveyed to find out whether they believe that the interests of the State are protected in judicial hearings about the mentally disabled. Although the directors would like to see better coordination of effort and communication between their staff and the State's legal representatives, the legal representation provided by the MHISs on one side and the State on the other is seen as an equal one.

Workload Derived from Legislative and Administrative Mandates

The MHISs have not established workload priorities in terms of legislative intent. That is, they do not maintain an information management (workload) system which distinguishes between activities which are legislatively mandated and those which are administratively mandated. By maintaining workload data in terms of legislative mandates, the MHISs would have a benchmark against which to measure their progress. Such information could then be used to make decisions about the most effective deployment of staff. The need for such a

management information system is demonstrated by the results of LCER's analysis of MHIS 1982 workload. Chart S-1 presents a comparison of the number of work weeks available in each MHIS in 1982 against the number of weeks of work reported as accomplished during 1982. In all MHISs, the work reported as accomplished exceeded the available manpower. Most important, however, is the fact that over two-thirds of the workload in each MHIS stemmed from administrative rather than legislative mandates. This analysis refutes MHISs' claim that it is the increase in legislative mandates which has brought about increased workload and a need for additional staff.

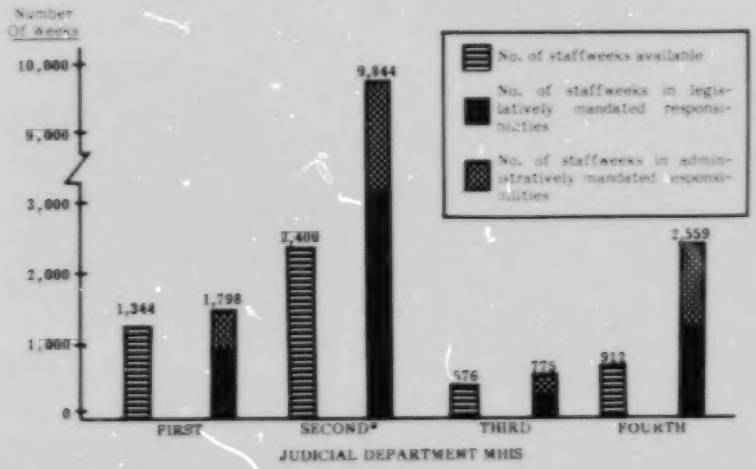
Conclusion

The results of the workload analysis plus the finding of the effectiveness study--that the majority of patients were not receiving legislatively mandated services--document that a shift has taken place away from the informational activities explicitly mandated in legislation toward the provision of legal/advocacy services mandated by administrative rules and regulations. Yet, an LCER survey of judges using MHIS services elicited very favorable responses. Most of the judges are pleased with the MHISs and the services they perform for the courts. A survey of OMH and OMRDD facility directors obtained their opinions about the quality of service provided by those representing the State's interest in judicial proceedings where the MHISs represent the patients. The facility directors reported that the interests of the State are well protected.

There is a lack of a coherent information management system, including less than adequate maintenance of MHIS patient files. As a result planned resource allocation is interfered with and accountability is lacking.

Chart S-1

Number of Staffweeks Available and Worked
On Legislatively Mandated and Administratively
Mandated Responsibilities By MHIS Department
1982



*No reduction for supervision or travel.

Source: LCER survey of MHIS Workload, November 1983.

Findings for Comment

Chapter 58 of the Laws of 1980 requires heads of audited agencies to report within 180 days of receipt of the final program audit to the Chairman of the Legislative Commission on Expenditure Review and the Chairmen and the Ranking Minority Members of the Senate Finance Committee and the Assembly Ways and Means Committee on what steps have been taken in response to findings and where no steps were taken, the reason why.

1. LCER review of the MHISs' files revealed that many of the legislatively mandated functions, intended to protect the constitutional rights of persons admitted to facilities for the mentally disabled, are not being performed. (p. 26)

2. The MHISs do not track workload in terms of legislative mandates. As a result, they are unaware of the extent to which they do not provide the constitutional protections to their clients expressly called for in State law. (p. 39)

3. Analysis of 1982 MHIS workload indicates that over 65 percent of the effort was devoted to fulfilling administrative mandates rather than legislative mandates. (p. 40)

4. There are no uniform statewide policies and procedures established regarding the recording and maintenance of MHIS documents. As a result, the four MHISs are unable to support their reported workload. Most importantly, they are unable to document that a patient's constitutional rights have been protected. Accurate records can be maintained as shown by one district in the Second Department MHIS where all activities were properly documented. (p. 40)

5. A shift in philosophy and function is taking place away from the information agency purposes originally intended when the MHISs were created. Administrative rules and regulations have made legal/advocacy services a central function of the MHISs. The information agency functions of the MHISs, specified in law, which help preserve the constitutionality of the New York State system of institutionalization of the mentally disabled are being supplanted by its legal/advocacy activities. (p. 40)

GLOSSARY OF TERMS

COMMITTEE--appointed by the court to care for the person and/or property of a person declared incompetent.

CONSERVATOR--appointed by the court to care for the property of a person who has not been declared incompetent but has suffered substantial impairment because of age, illness, infirmity, mental weakness, alcohol or substance abuse and is unable to care for his property or provide for himself or his dependents.

FACILITY--any place in which services for the mentally disabled are provided and includes but is not limited to a psychiatric center, developmental center, institute, clinic, ward, institution, or building. It does not include a place where the services rendered consist solely of non-residential services for the mentally disabled nor shall it include domestic care and comfort to a person in the home.

HOSPITAL--the in-patient services of a psychiatric center under the jurisdiction of the Office of Mental Health or other psychiatric in-patient facility in the department, a psychiatric in-patient facility maintained by a political subdivision of the state for the care or treatment of the mentally ill, a ward, wing, unit, or other part of a hospital, as defined in article twenty-eight of the public health law, operated as a part of such hospital for the purpose of providing services for the mentally ill pursuant to an operating certificate issued by the commissioner of mental health, or other facility providing in-patient care or treatment of the mentally ill which has been issued an operating certificate by such commissioner.

INCAPACITATED PERSON--a defendant who as the result of mental disease or defect lacks capacity to understand the proceedings against him or assist in his own defense.

INFORMAL STATUS--admission of a suitable person in need of care or treatment who requests admission. Person need not make formal or written application and may leave at any time. Suitability is determined by the same criteria used in voluntary status.

INVOLUNTARY STATUS--admission and/or retention of a mentally ill or mentally retarded/developmentally disabled person where care and treatment in a hospital/school is essential to the person's welfare and the person's judgment is so impaired that he is unable to understand the need for care and treatment.

JACKSON PROCEEDINGS--take their name from the U.S. Supreme Court case Jackson v. Indiana (406 U.S. 715, 1973) in which the court held that when a defendant is incapable of standing trial because of mental disease or defect--does not understand the charges against him and/or cannot assist in his own defense--and is committed to a mental hygiene facility, he cannot be held as an incapacitated defendant indefinitely. He must make reasonable progress toward becoming competent in a reasonable period of time or be converted to civil status.

NON-OBJECTING STATUS--admission and retention of any person in need of care and treatment who does not object and who is so profoundly or severely mentally retarded that he does not have sufficient understanding to make him suitable for admission as a voluntary patient.

OLD LAW PATIENTS--those who were admitted prior to the point when the MHISs were given responsibility for their oversight.

SCHOOL--the in-patient service of a developmental center or other residential facility for the mentally retarded and developmentally disabled under the jurisdiction of the Office of Mental Retardation and Developmental Disabilities or a facility for the residential care, treatment, training, or education of the mentally retarded and developmentally disabled which has been issued an operating certificate by the commissioner of mental retardation and developmental disabilities.

VOLUNTARY STATUS--admission of a suitable person in need of care or treatment who makes voluntary application for admission. Suitability is determined by the ability to understand:

--the nature of the facility to which he is requesting admission;

--that he is applying for admission;

--the nature of the voluntary status and provisions governing release or conversion to involuntary status.

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FOREWORD

The Legislative Commission on Expenditure Review was established by Chapter 176 of the Laws of 1969 as a permanent legislative agency for among other duties, "the purpose of determining whether any such department or agency has efficiently and effectively expended funds appropriated by the Legislature for specific programs and whether such departments or agencies have failed to fulfill the legislative intent, purpose and authorization," and to "make a comprehensive and continuing study of . . . the program and expenditures by state departments." The program audit, The Mental Health Information Services, is the one hundred sixteenth staff report.

The audit reviews the provision by MHISs of protective information services to patients, their families and the courts and provides the Legislature with an evaluation of MHIS workload. The audit concludes that the MHISs are failing to provide the basic constitutional guarantees, required by statute, to the majority of mentally disabled persons, as shown by an LCER sample of MHIS files. An analysis of MHIS activity demonstrates that a large proportion of staff resources are not used to carry out duties mandated by statute but rather to perform functions made mandatory by the Presiding Justices, through exercise of legislatively granted administrative discretion.

Appreciation is expressed to the MHISs and their district offices. Appendix E contains the MHISs' response to this study along with an LCER rebuttal.

In accordance with Commission policy, this report focuses on factual analysis and evaluation. Recommendations and program proposals are not presented since they are in the realm of policymaking and therefore the prerogative of the Legislature.

The audit was conducted by Joan Deanehan, Chairperson, and Karen McNamara. Data processing services were provided by Linda Lux with the assistance of David Rowell. Research assistance was provided by Lynne Aronson and William Ryan. James Haag handled layout and production. Word processing and graphics services were provided by Ann Careccia. Overall supervision was the responsibility of the Acting Director.

The Commission is interested in hearing from the readers of its audits. Any comments or suggestions should be sent to the Acting Director at the address listed inside the front cover of the audit.

The law mandates that the Chairmanship of the Legislative Commission on Expenditure Review alternate in successive years between the Chairman, Senate Finance Committee and the Chairman, Assembly Ways and Means Committee. Assemblyman Arthur J. Kremer is Chairman for 1984 and Senator John J. Marchi is Vice Chairman.

May 21, 1984

Bernard P. Geizer
Acting Director

I INTRODUCTION

Mental Health Information Services

The Legislature of 1964 created four Mental Health Information Services (MHIS) in New York State to ensure the provision of constitutionally guaranteed due process and equal protection of the laws to persons admitted to facilities for the mentally disabled. An MHIS is located in each of the four judicial departments of the Appellate Division of the Supreme Court and is headed by the presiding justice of each department. Day to day operation is the responsibility of a director appointed by the presiding justice. The MHISs were placed in the judiciary in order to guarantee their independence and freedom from interference. The purposes of this study are to:

--Evaluate the effectiveness with which legislatively mandated information services to the mentally disabled and the courts were carried out; and

--Provide the Legislature with an evaluation of workload and activity to be used in responding to the MHISs' requests for staffing increases.

When they began operation in 1965, the Mental Health Information Services were organized to conform with the existing judicial administrative structure. Thus, a Mental Health Information Service was established in each of the four judicial departments of the Appellate Division of the Supreme Court and each was under the direction of a different presiding justice. This organization did not allow for a uniform, statewide structure nor for an equal workload.

Service Area

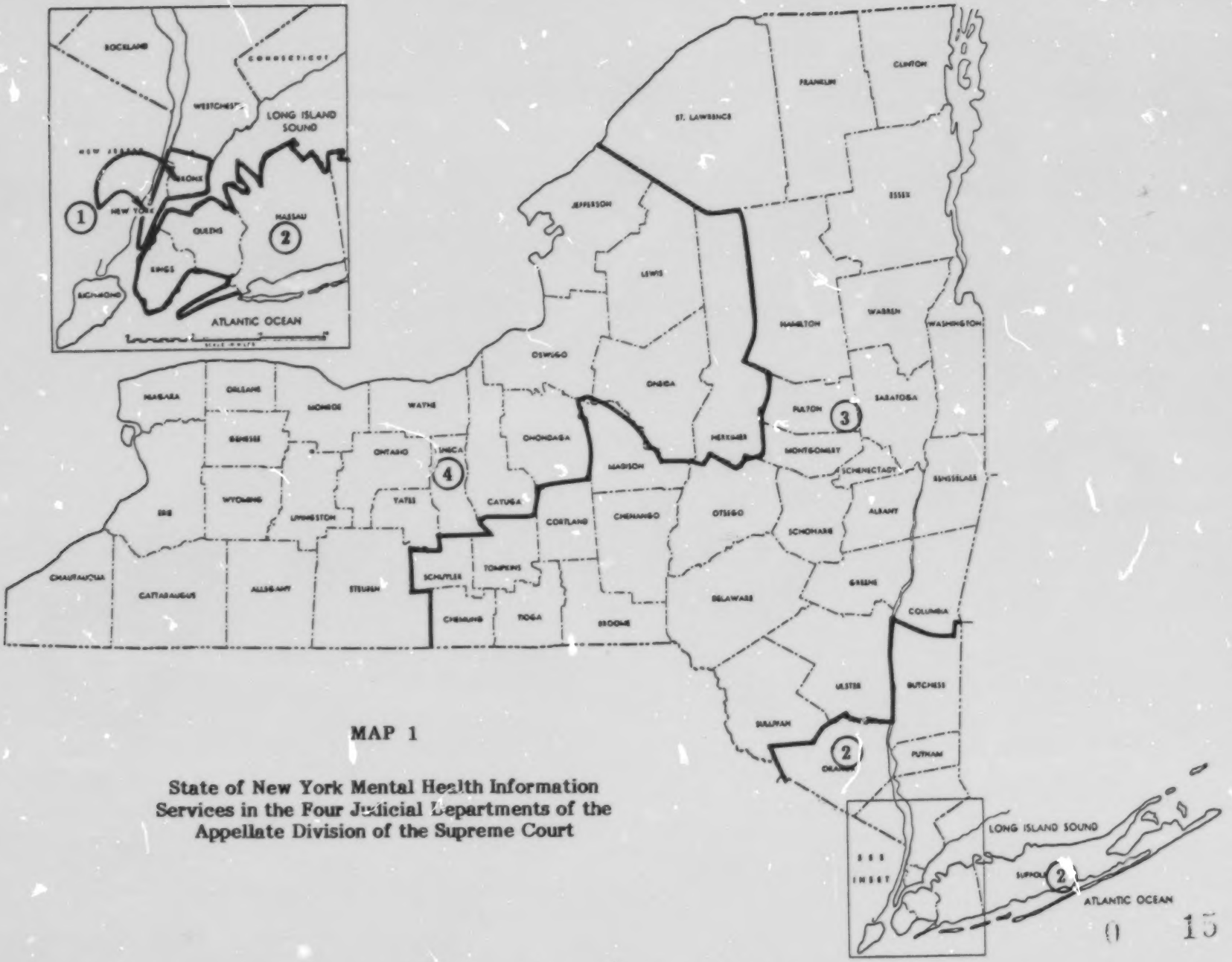
One of the most striking differences among the MHISs is their geographical areas. (See Map 1.) The First Judicial Department covers two urban counties--Manhattan and the Bronx. The service area of the Second Judicial Department includes the New York City counties of Kings, Queens and Richmond, all of Long Island and five upstate suburban counties. The Third Judicial Department represents the most rural and the largest geographic area; its territory extends from the Southern Tier to New York's northern borders. The Fourth Department encompasses 22 urban, suburban and rural counties in the western part of the State. Table 1 presents geographic and total population data for each Judicial Department MHIS.

Table 1

Geographic and Population Data For Each MHIS Service Area

	Judicial Department MHIS			
	First	Second	Third	Fourth
Number of Counties	2	10	28	22
Total Area-Sq. Mi.	64	3,950	24,934	18,883
Total Population	2,596,648	8,788,175	2,329,542	3,842,923

Source: 1979-80 New York State Statistical Yearbook and 1980 Census data.



MAP 1

State of New York Mental Health Information Services in the Four Judicial Departments of the Appellate Division of the Supreme Court

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Scope and Methodology

As will be shown in the legislative and program intent section, the MHISs were intended by the Legislature to function as information providing agencies--to use information as a tool to help patients, their families and the courts to (1) protect patients' rights against wrongful deprivation of liberty while at the same time not cutting them off from the psychiatric care and treatment they needed, and (2) protect society's interests. The term "patient" is used generically to mean the service populations defined in the Mental Hygiene Law, whether mentally ill, mentally retarded or developmentally disabled. Chapters I and II will address issues related to program effectiveness. These chapters will focus on:

1. A critical analysis of legislative and program intent and the relationship between the two.
2. Whether MHIS patient files reflect the provision of the information services to patients and families required by law.

File Search

In order to determine if required services were provided LCER staff examined case files in the four judicial department MHISs. (See detailed explanation of sample design in Appendix B.) The standard used was whether written documentation was present that the following protections had been provided by MHIS staff:

--Study and review of each admission and retention.

--Notice, via face-to-face interview, of the proper procedures for admission and retention, rights to hearing and review, representation by counsel and to seek independent medical opinion.

--Investigating cases of alleged abuse and mistreatment, and taking legal action, including direct representation, to protect patients.

--Annual reviews of the suitability and willingness of a voluntary or informal patient to remain on that status.

--Annual review of the retention of mentally retarded/developmentally disabled patients on non-objecting status.

--Annual review of suitability and willingness of conditionally released patients.

Absent written documentation the service was considered not to have been provided. Written proof of services having been provided, in the patients file is necessary for effective management and supervision. If the provision of constitutional protections is ever at issue in a court case, documentation in the file will be essential.

Surveys

3. How judges view the information services they receive in the form of information reports to the courts.

County Court, Supreme Court and Surrogate's Court judges were surveyed for their opinions of the "information reports" they are receiving from the MHISs. In interviews

and in the workload data submitted to LCER, the MHIS directors have stated that they no longer provide the courts with the information reports described in legislation. Instead they provide memoranda of law. The survey provided LCER with information about whether the memorandum of law is an acceptable substitute for the information report.

4. Whether administrative rules, promulgated by the presiding justices in each of the judicial departments, in the Official Compilation of Codes, Rules and Regulations of the State of New York (NYCRR), are bringing about a nearly complete shift in agency orientation so that although legislative intent continues to emphasize the agencies' information providing roles, management decisions have created program intent favoring direct legal representation of clients and participation in judicial hearings.

Included in Chapter II is a survey of directors of Office of Mental Health (OMH) and Office of Mental Retardation and Developmental Disabilities (OMRDD) facilities asking their opinions of the quality of legal representation of the State's case in judicial proceedings where the patient's case is presented by MHIS staff.

Workload Study

The MHISs have contended that their large workloads result from legislative action over the past 18 years increasing the scope and number of their responsibilities. They further maintain that their staffing is inadequate to meet the increased workload. Therefore, they have requested staffing increases in each of their budget submissions over the past five years. The workload portion of the audit in Chapter III will determine what the workload is of each MHIS; whether the information management system in place is adequate to control and measure workload; and whether the workload derives from legislative mandates or is mandated administratively by rules and regulations promulgated by the presiding justices. LCER staff designed a reporting form which classified individual activities by whether they were legislative mandates or administrative mandates. The MHISs were asked to complete the workload summaries including counts of the numbers of activities done as well as estimates of the average time it took to perform the activity. The LCER analysis of workload is in Chapter III. The use of the term "mandate" in this audit is intended to have the following narrow and specific meanings:

--An authoritative order or command,

--A command, order, or direction which ... [a] person is bound to obey.[1]

LCER staff have classified as mandates those sections of law or regulation which use the word "shall." Those sections using the word "may" are considered to be permissive or discretionary. Sections of law relating to MHIS activity are classified in Appendix C.

Legislative and Program Intent

The Creation of the MHISs

> Any person hospitalized against his will is entitled to watchful protection of his rights, because he is a citizen first and a mental patient second.[2]

That was the principle guiding the Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York when it made the recommendations which two years later led to the creation of the Mental Health Information Services. Chapter 738 of the Laws of 1964 restructured the procedures for admission and retention of involuntary patients to psychiatric facilities. The system of judicial certification (commitment) which existed in the State prior to September 1965 had been criticized by the Special Committee in its 1962 study, Mental Illness And Due Process. The study, conducted in conjunction with the Cornell Law School, found an absence of due process protections for that large majority of patients who underwent judicial certification by the courts to mental hygiene facilities. The patient was entitled to a judicial hearing prior to certification, but hearings were rarely held. When hearings were held the patient had most frequently not received notice, was not represented by counsel and did not appear.[3] "Notice of the right to a hearing may be waived on a showing that the notice would be useless or harmful to the patient. In practice only a small proportion of patients--less than ten percent throughout the [S]tate--ever have a hearing. Outside New York City the hearing is hardly ever held; the patient generally gets no notice of his right to one."[4] Initial court ordered certification permitted the facility to hold the patient for 60 days. Within that time period a second court order could be applied for permitting the patient to be held indefinitely. Once admitted "the law of inertia" took effect and patients tended to remain institutionalized for long periods without medical or legal review of the case being required.

Information Services To Take Priority

The memoranda supporting passage of Chapter 738 and the Governor's memorandum of approval demonstrate that the MHISs were not created or intended to be legal representation services. Legal representation may be a logical extension of the information agency functions, but it is not supposed to take precedence over them. In its memorandum the Special Committee said that the MHISs were created "[t]o insure that all involuntary patients may be acquainted with their rights and to insure that . . . the courts will have adequate information on which to base an informed judgment. . ."[5] The Governor referred to the ". . . establishment of a Mental Health Information Service, as an arm of the judiciary, to gather information for the court and to advise patients and their relatives of their rights under the law."[6] Although the Division of the Budget (DOB) recommended that the bill be vetoed because problems in administration were envisioned, its description of the agency to be created was the same as the others: ". . . informing patients and their families of their rights and will assemble and provide the necessary information regarding each patient for use by the court."[7] With minor variations the same perception was shared by others including the Department of Mental Hygiene, the Administrative Board of the Judicial Conference and the New York State Bar Association. In his statement of support, the Chairman of the Committee on Mental Hygiene of the State Bar Association discussed legal representation in relation to the MHISs. He remarked ". . . the Service would also be empowered to recommend to the courts in particular cases the appointment of counsel for the patient. . . ."[8]

Since the creation of the MHISs legislative action has expanded their roles. They have a more broadly defined service population--those for whom they must act. Chapter 251 of the Laws of 1972 recodified the Mental Hygiene Law, to, among other things, expand the MHISs' responsibilities to cover all patients admitted to facilities for the mentally disabled. As of December 1983, at least six functional mandates had been added. The MHISs:

--Shall contact juvenile delinquents temporarily transferred to OMH or OMRDD custody;

--May be required to act in the capacity of guardian ad litem in conservatorship proceedings;

--Must provide information reports to the courts in proceedings to appoint a committee;

--Are required to investigate alleged patient abuse and mistreatment and take legal action to protect patients;

--Must review the suitability and willingness of a voluntary/informal patient to remain on that status every 12 months; and

--Must conduct annual reviews of non-objecting mentally retarded/developmentally disabled admissions.

Furthermore, many more opportunities have been created where the MHISs may act.

A central issue arising from legislative intent is the difference between those MHIS functions explicitly required by law and those which are implicit and which may flow from that first set of duties. It is the second set of responsibilities which are made mandatory by the administrative regulations promulgated by the presiding justices. (Exhibit I differentiates between legislative mandates and administrative mandates.) When agency resources are limited service priorities have to be established and resources allocated accordingly. Carrying out the functions explicitly mandated in law should take priority over those which are permitted by law and mandated by administrative regulations.

The functions and services to be performed by the MHISs are defined in subsection (b) of section 29.09 of the Mental Hygiene Law (MHL) amplified by other sections of law. Certain responsibilities are explicitly defined and mandated at the same time that broad discretion is given to the presiding justices to structure and administer the MHISs. The MHISs ". . . shall perform the following duties subject to directions made and rules and regulations promulgated by the presiding justice of the appellate division of each department." Paragraphs one, two, three and five of subsection (b) contain the legislative mandates to:

--Study and review all admissions and retentions;

--Inform patients and others about admission and retention procedures and patients' rights to judicial hearing and review, representation by counsel and to seek independent medical opinion;

--Prepare information reports for the courts concerning the patients' case, hospitalization, right to discharge and need for appointment of counsel or additional psychiatric opinion; and

--Investigate and take legal action, including representation, to protect patients against abuse and mistreatment.

Subsection (c) grants the MHISs physical access to mental hygiene facilities and to pertinent data and information to carry out necessary services, functions, powers and duties. Paragraph four states that the MHIS's are to:

provide services and assistance to patients and their families and the courts having duties to perform relating to the mentally disabled or the

EXHIBIT I

Mental Health Information Service
Legislatively Mandated Activities and Administratively Mandated Activities

Informational Activities

Legislatively Mandated	Administratively Mandated
Review all admissions and retentions (Section 29.09 MHL).	Review of hospital charts.
Inform patients and others of procedures, right to hearing and review, representation and independent medical opinion (Section 29.09 MHL).	Provision of general information about legal matters to non-institutionalized persons (includes training and education for facility personnel and other interested groups).
Provide information reports to the court (Section 29.09 MHL).	Investigate and report to the court in cases regarding: the appointment of a conservator pursuant to the Mental Hygiene Law or the appointment of a guardian pursuant to Article 17-A of the Surrogate's Court Procedure Act.
	Liaison with Board of Visitors.
Investigate cases of abuse and mistreatment (Section 29.09 MHL).	
Review the suitability and willingness of conditionally released patients every 12 months (Section 29.15 MHL).	
Annual review of persons on non-objecting status (Section 15.25 MHL).	
Review suitability and willingness of voluntary/informal status patients annually (Section 9.25; 15.23 MHL).	
Investigate and report to the court regarding: suitability of appointment of committee (Section 78.07 MHL).	
MHISs to see juvenile delinquents admitted to OMH/OMRDD facility (Section 9.49; 15.37 MHL).	

Legal/Advocacy Activities

Legislatively Mandated	Administratively Mandated
Take legal action (including representation) to protect patients against abuse and mistreatment (Section 29.09 MHL).	Legal representation of patients in admission, retention, habeas corpus, Criminal Procedure Law, Correction Law and Family Court Act proceedings.
MHISs to act as guardian ad litem in conservator proceeding, if assigned by judge (Section 77.07 MHL).	Legal representation of patients in conservator, committee (Articles 77 and 78 MHL) and guardianship cases (Article 17-A SCPA).
	Legal representation of patients in court authorized medical/surgical procedures.
	Administrative appeals of treatment.
	Advocacy services.
	Obtaining services of attorneys and psychiatrists pursuant to Section 35 of the Judiciary Law.
	Miscellaneous litigation, including, but not limited to appeals. Civil Practice Laws and Rules, Article 78 proceedings, temporary restraining orders.

Source: Legislatively mandated activities compiled by LCER staff from McKinney's Consolidated Laws of New York Annotated: 34A Mental Hygiene Law. Administratively mandated activities compiled by LCER staff from 22 NYCRR and from responses to LCER Survey of MHIS Workload, November 1983.

> allegedly mentally disabled, who are admitted pursuant to articles [9, 15 and 21] of this chapter, as may be required by a judge or justice thereof and pursuant to the regulations of the presiding justice of the appellate division of each judicial department.

The presiding justices have interpreted this paragraph as providing implicit permission for the MHISs to provide their service population with direct legal representation other than in abuse cases. They have used the rules and regulations (22 NYCRR 622.2, 694.3, 823.2, 1023.2) to implement this advocacy role and have thereby changed the philosophical and functional orientation of the MHISs. This is true even in the Fourth Judicial Department MHIS which is staffed primarily with non-lawyer information officers. As detailed by the First Judicial Department MHIS's first director in a 1975 article

> After approximately one year, the Presiding Justice of the Appellate Division, First Department, directed the Administrative Justice to instruct the Justices of the Supreme Court that guidelines had been fixed for the representation by the Mental Health Information Service of all mental patients who were hospitalized.[9]

Program intent as defined by the administrative rules and regulations for each of the four judicial department MHISs is almost always consistent with the intent of section 29.09 MHL and/or other sections of law. However, parts 622.2(a)(2) (First Department); 694.3(a)(2) (Second Department); 823.2(a)(2) (Third Department); and 1023.2(a)(2) (Fourth Department) require that in every case requiring court action (with or without a hearing) the patient's case is to be investigated, the records examined and the patient and others interviewed. Even when the patient has private counsel the court may require the MHISs to act. The regulations appear to require the MHISs to perform some of the information report duties found in section 29.09(b)(3) MHL but does not require a report to be submitted to the court. Some of the regulations amplify legislative intent. Those applying to the appointment of a conservator, committee, or guardian do so. Regulations which detail required MHIS services to persons in mental hygiene facilities pursuant to Correction Law (Corr.L) or Criminal Procedure Law (CPL), also do so.

Application of the MHIS Statute

Other sections of law and regulations augment or implement the mandates on the MHISs to monitor State or facility actions affecting personal liberty, as they apply to various classes of persons they serve. Most are either mandates on the agencies being monitored or are written to permit, but not require, MHIS action. These sections are found in the Mental Hygiene Law, Criminal Procedure Law, Corrections Law and Surrogate's Court Procedure Act (SCPA). In the Mental Hygiene Law, Articles 9 (applying to psychiatric facilities) and 15 (applying to facilities for the mentally retarded and developmentally disabled) require that facility directors provide notice to the MHISs of facility actions which have the potential of affecting physical freedom or access by the MHISs. Other than section 21.11 of Article 21 requiring that the services of the MHISs be available to minors admitted to alcoholism facilities there are no other requirements concerning the MHISs in that Article. Articles 9 and 15 require that facilities notify the MHISs about:

--All admissions;

--Transfer of involuntary patients;

--Transfer of minors without patients' prior consent and parent/guardians' prior written consent;

--Conversion of status of a minor and discharge or transfer;

--Conversion from involuntary to voluntary status;

--Request by facility director for involuntary retention;

--Patients' requests for hearings.

Suitability and willingness review. In addition to the reviews required in section 29.09 MHL, the MHISs are to conduct periodic reviews of the suitability and willingness of a voluntary, informal or conditionally released patient to remain on that status (sections 9.25, 15.23, 29.15 MHL) and the retention of mentally retarded/developmentally disabled patients on non-objecting status (section 15.25 MHL). The MHIS review is intended to prevent these categories being used as catchalls and allowing patients to be "warehoused."

The MHISs may act independently of the patient to seek relief on the patient's behalf. They are authorized to:

--Make written request to facility directors for the release of minors on voluntary status and apply to the courts if the request is denied (sections 9.13, 15.13 MHL),

--Make written request to facility directors for release of non-objecting mentally retarded/developmentally disabled patients forcing the facility to go through the formal procedure to retain an involuntary patient (section 15.25 MHL),

--Make written notice to facility directors of the request for a hearing on the issue of need for involuntary admission or retention (sections 9.31, 9.33, 9.37, 9.39, 15.31, 15.33 MHL),

--Request a hearing to question the return of an involuntary patient on conditional release to the facility (sections 29.15 MHL),

--Make application to the court for a court order determining the questions of suitability and/or willingness to remain on voluntary status and request a hearing (sections 9.25, 15.23 MHL).

At least once each year client service reports are to be prepared for each person receiving services in an OMH and OMRDD facility. With the consent of the patient and the OMH and OMRDD Commissioners the report may be made available to the MHISs (section 29.18 MHL).

Appointment of conservator, committee, or guardian. In proceedings to appoint a conservator (Article 77 MHL) or a committee (Article 78 MHL) for a person in a facility for the mentally disabled, the courts rely on the MHISs to speak on behalf of the patient. In conservatorship proceedings they have "the right to be heard in all phases of the proceedings" (section 77.01 MHL) and are, therefore, to receive notices concerning the proceeding and copies of certain accounts made to the courts by the conservator (sections 77.07, 77.08, 77.31 MHL). The MHISs may be asked by the courts to assume the

role of guardian ad litem (to temporarily and for that proceeding only act as protector of the interests of the patient) (section 77.07 MHL). When the court is considering the appointment of a committee for the patient the MHISs are to receive notices concerning the proceeding (sections 78.03, 78.07 MHL) and are to provide the courts with information reports "as to the suitability of the appointment of a committee in accordance with rules and regulations promulgated by the presiding justice . . ." (section 78.07 MHL). Section 1705 of the Surrogate's Court Procedure Act requires that the MHISs be notified when an application is made for the appointment of a guardian for a mentally retarded person who has been admitted to a facility.

The regulations of the presiding justices expand the duties in conservator, committee or guardian proceedings to include in every proceeding:

--Determining that notices to all parties and proper procedural requirements have been carried out;

--Examining medical, psychiatric or other records relating to the case;

--Interviewing the patient and advising about the proceeding, his legal rights; and determining if he objects to the proceeding or the person proposed as conservator, committee or guardian;

--Interviewing medical personnel;

--Determining the extent and nature of the patient's assets;

--Obtaining information about the patient's social history;

--Notifying the court of any hearing request;

--Attending and participating in hearings on the patient's behalf;

--Submitting an information report to the court;

--Keeping the patient abreast of proceedings including judicial accountings;

--Effecting the issuance of a certificate of competency; and

--Applying for the dismissal of the conservator, committee or guardian.

Criminal Proceedings

When persons involved in criminal proceedings are unable to stand trial because of mental disease or defect, or are not guilty by reason of mental disease or defect they come in contact with the State's mental health establishment and with the MHISs.

Incapacitated defendants. The MHISs are to be notified by facility directors when:

--The defendant is admitted on an order of commitment; or

--An order of retention is applied for (Article 730 CPL).

The MHISs may demand a hearing on the issue of continued retention (section 730.50 CPL).

Not responsible by reason of mental disease or defect. When a defendant is found not responsible by reason of mental disease or defect the court must issue an examination order to determine the person's present mental condition. The MHISs are to receive copies of those examination orders and "may thereafter participate in all subsequent proceedings under this section" (section 330.20 CPL). Copies of the examination reports are to be sent to the MHISs. A hearing must be held to determine the person's present mental condition. The court must make one of the following three findings:

--If the defendant has a dangerous mental disorder the court must issue a commitment order;

--If the defendant is mentally ill but not dangerous the court must issue an order of conditions and an order committing the person to OMH or OMRDD. At this point Articles 9 or 15 MHL apply; or

--If the defendant does not have a dangerous mental disorder and is not mentally ill the person must be released, with or without an order of conditions.

If the person is found mentally ill but not dangerous the provisions of the Mental Hygiene Law are implemented applying to civil patients as discussed earlier. If the court finds that the person has a dangerous mental disorder and issues an order of commitment the person is held for six months with subsequent first retention for one year and two years thereafter. Notices of the retention applications and any other application potentially affecting the person's personal liberty are to be sent to the MHISs. Subject to the limitations of the CPL the person has the same rights granted to other patients under the MHL including access to the MHISs. The regulations require the MHISs to act in all cases in which they are required to receive notice. They are to:

--Make sure that all of the notices required are given and that proper procedures are complied with;

--Interview the inmate, defendant or patient, inform him of his rights including hearing and representation;

--Demand a hearing or court review on the inmate, defendant or patient's behalf;

--Examine the inmate, defendant or patient's hospital record and interview medical staff;

--Interview other persons with relevant information;

--Perform any services for the inmate, defendant or patient as the court may request or the director may determine;

--Represent the inmate, defendant or patient in the above proceedings if he does not have counsel of his own choosing (mandatory in First and Second Departments, optional in Third and Fourth Departments).

Administrative mandate six above results in MHIS staff becoming involved in "Jackson" hearings and proceedings to vacate indictments when a time period equal to two-thirds of the maximum sentence for the highest class felony charged in the indictment has expired (section 730.50 CPL).

Inmates of correctional facilities. If, after examination by two physicians, an inmate of any State or local correctional facility is found to be mentally ill application is to be made to a judge for his commitment to a facility for the mentally ill (section 402, Corrections Law). The MHISs are to provide the inmate with notice of his rights to hearing, review, representation and independent medical opinion and to that end are to receive a copy of the notice given to inmates, and the application and physicians' certificates certifying that the inmate is mentally ill. When there is a likelihood of harm to himself or others an emergency commitment may be made to the Central New York Psychiatric Center with the hearing afterward.

Chapter Summary

● One Mental Health Information Service (MHIS) is located in each of the four judicial departments of the Appellate Division of the Supreme Court. They were created by the Legislature of 1964 to ensure the provision of constitutionally guaranteed due process and equal protection of the laws to persons admitted to facilities for the mentally disabled.

● There are two types of functions to be performed by the four MHISs. One set of duties is defined and mandated in legislation. The second is permitted by legislation and is made mandatory in the administrative rules promulgated by the presiding justices. The duties mandated in law are intended to take priority over those mandated in regulation.

● While legislative action has given the MHISs some added responsibilities in the 18 years since their inception and has broadened their service population; many of their current duties result from administrative mandates.

II PROGRAM EFFECTIVENESS

Legislative Commission on Expenditure Review (LCER) staff used three instruments to gauge the effectiveness of the MHISs' activities. First, a file search was conducted in which sample cases were drawn from the MHISs' files to find out if the protective services they were required to provide were delivered. The files also were reviewed to determine what non-mandated services were being carried out and the general condition of the files. Second, judges were surveyed to see what they thought of the information reports submitted by the MHISs and the MHISs themselves. There has been some controversy about a possible conflict of interest between the information report function (a legislative mandate) and direct legal representation (an administratively created function). In the four judicial Departments the information reports have given ground. What has that meant to the judges who use them?

The third measure was a survey of directors of State facilities for the mentally disabled who were asked if they think the adversary relationship--facility representative vs. MHIS staff and/or assigned counsel (Fourth Department)--is balanced. One issue raised when the MHISs were created was that of balancing the interests of society at large with those of the individual patient. It has been suggested that the specialization of the MHISs' attorneys gives them an advantage over the staff and/or attorneys representing the facility's/State's interests.

Sample of MHIS Files

The sample was designed by LCER staff with assistance provided by staff of the OMH and OMRDD. Included in the sample were general hospital patients, State psychiatric center patients and residents of State mental retardation facilities. The two latter categories included, in addition to in-patients, persons on conditional release from State facilities. Separate samples were drawn for patients in State facilities and for those in general hospitals. Table 2 presents data on the samples selected for each MHIS. Further information on sample design is provided in Appendix B.

Table 2

LCER Survey of MHIS Files
Sample Number of Cases by Type for Each MHIS

Type of Facility	Judicial Department MHIS			
	First	Second	Third	Fourth
OMH	55	93	57	85
OMRDD	47	71	79	90
General Hospital	97	96	64	86
Total	199	260	200	261

Source: Compiled by LCER staff from MHIS case files.

Provision of Protective Services

LCER's data collection form was designed to capture the extent to which the MHISs performed certain legislative and administrative functions. Information was gathered about MHISs' performance of: (1) activities basic to ensuring an individual's constitutional protections--admission review, notice of rights through interview, review of retentions and, (2) other mandated activities such as annual reviews. The final portion of the form recorded information on the condition of the files.

Admission review. More than 80 percent of the 722 eligible cases examined--with "old law" (see glossary of terms) admissions excluded--showed no evidence of having undergone MHIS admission review (Table 3), even though monitoring by MHIS of every admission is required by law (section 29.09 MHL). The percent of cases reviewed varied from a high of 28 percent in the Second Department to a low of 9 percent in the Third Department. Evidence accepted by LCER staff as documentation of a review included admission sheets clearly initialed and dated by MHIS staff, memoranda of law which contained specific dated reference to a review or interview on or about the date of admission, and scraps of yellow paper which indicated that some part of the review had been done.

Involuntary status. The patient most likely to have had his admission reviewed was admitted to an OMH facility on involuntary status. (Appendix B-Tables B-2 through B-4). The Second Department MHIS (Table B-2) reviewed 55 percent of the involuntary admissions in its sample--by far the highest rate achieved. Sixty-four percent of involuntary admissions to OMH facilities in the Second Department were reviewed while only 11 percent of admissions to the general hospital were reviewed. In the First and Third Departments (Table B-2) overall rates of 27 percent were attained with the Third Department reviewing 57 percent of OMH admissions and none of those admitted to the general hospital. In the First Department the rates were 51 and 13 percent, respectively. The Fourth Department (Table B-2) reviewed 25 percent of involuntary status admissions

Table 3

Adequacy of Admission Review by
Judicial Department MHISs

Judicial Department MHIS	Admissions Reviewed*			
	Yes	No	Not Applicable	(n =)
First	23%	76%	1%	190
Second	28	71	2	182
Third	9	91	--	173
Fourth	12	85	2	177
Total	18	81	1	722

*Excludes "old law" patients (n = 198).

Source: Compiled by LCER staff from data obtained from MHIS files.

overall-- 38 percent of those to OMH facilities and 14 percent of those to the general hospital.

Voluntary status. The largest proportion of voluntary status patients were admitted to general hospitals and very few of those admissions were reviewed (Table B-3). First Judicial Department records showed documentation of 22 percent of voluntary status admissions in the sample being reviewed. Only five percent of hospital admissions, which were nearly 50 percent of the total of voluntary admissions, showed evidence of MHIS attention. In the Second Department 19 percent of voluntary admissions were reviewed. However only two percent of the general hospital admissions--which were 74 percent of all Second Department voluntary admissions--were checked by MHIS staff. The Third Department MHIS reviewed five percent of all eligible voluntary admissions in the sample. None of the general hospital patient admissions--51 percent of the total--were reviewed. None of the Fourth Department voluntary admissions were reviewed. As was true for involuntary admissions, OMH admissions were reviewed with the greatest frequency.

Non-objecting status. All non-objecting status admissions were to OMRDD facilities (Table B-4). The highest proportion of reviews documented was found in the Second Department--36 percent. In the First and Fourth Departments, 84 and 88 percent, respectively, of the admissions went unreviewed. The Third Judicial Department MHIS reviewed none of the non-objecting admissions in the LCER sample. In some ways the non-objecting population is the most vulnerable to abuse of their rights since they are least able to speak out in their own behalf. Watchful protection of their rights is critical and the MHISs are not providing it as evidenced by LCER staff review of case files.

Number of days until review. Of those admissions which were reviewed and where a date of review could be identified LCER staff calculated the average number of days from date of admission to date of review. Of the 920 cases in the sample, 157 (17 percent) had both admission and admission review dates identifiable in the case file. Table 4 presents the analysis of the data from those cases. Though the data are flawed, they show that involuntary status patients in the First Department MHIS receive the most

Table 4

Average Number of Days From Date of
Admission to Date Of Admission Review By Status

	Judicial Department MHIS							
	First		Second		Third		Fourth	
Status	Mean Number of Days	n	Mean Number of Days	n	Mean Number of Days	n	Mean Number of Days	n
Involuntary	6	67	15	22	14	9	20	14
Voluntary	10	18	20	18	19	3	--	--
Non-objecting	18	2	64	4	--	--	--	--

n = 157 (includes 48 partially reviewed cases where only initialed notice of rights sheet was present in the First Department.)

Source: Compiled by LCER staff from data obtained from MHIS case files.

prompt review of admission--the average number of days elapsed being six. Voluntary status admissions were reviewed in an average of ten days. The Second and Third Departments each took an average of two weeks to review involuntary admissions and three weeks to review the admissions of patients on voluntary status. The Fourth Department's review of involuntary status admissions took an average of three weeks. The law requires that patient records be sent to the MHISs (not including informal status admissions) not later than five work days from the date of admission (sections 9.11, 15.11, 9.39 MHL). Since the review is a paper review of procedural correctness, it should not take more than the average number of days attained by the First Judicial Department--six to ten work days--in reviewing involuntary or voluntary status admissions.

Notice of rights interview. One of the basic measures of MHIS effectiveness was whether patients had been informed of their rights by MHIS staff. LCER sample data were analyzed to determine what percent of patients had been interviewed (see Appendix Table B-5). In none of the four departments did even one-third of the eligible sample case files contain evidence of an interview. The highest percentage was in the Second Department where 26 percent of the 182 sampled cases were interviewed. The lowest percentage was found in the Third Department where only five percent of 173 cases contained evidence that the patient had been informed of his rights by MHIS.

Though the law requires that all patients be informed of their rights, MHIS directors told LCER staff that their priority was interviewing the involuntary status patient who had been hospitalized without his own consent. Even this analysis demonstrates that between 50 and 87 percent of the sampled involuntary cases had not been interviewed (see Table 5).

The data presented in each case, for involuntaries alone and for all status patients, show the Second Department MHIS to be significantly better than the other MHISs. This may reflect a policy within one district in the Second Department which calls for the use of an MHIS interview sheet. This form which contains the name of the patient and is dated and signed by the interviewer, is an effective management tool allowing supervisors to keep track of work accomplished on a patient by patient basis.

Table 5

Percent of Involuntary Status Clients Receiving
Notice of Rights Interview by Judicial Department MHIS

Judicial Department MHIS	Involuntary Admissions Reviewed		
	Yes	No	(n =)
First	15%	85%	118
Second	50	50	44
Third	13	87	45
Fourth	13	87	75
Total	20	80	282

Source: Compiled by LCER staff from data obtained in MHIS case files.

In summary, the MHIS files indicate that the majority of patients of all statuses (voluntary, involuntary and non-objecting) are not being provided the basic constitutional protection mandated in law and they are not being advised of their rights by MHIS staff.

Review of retention. In general retentions were reviewed (Table 6). Two factors probably contributed to the high percentage of completed reviews: (1) the comparatively small size of the population, and (2) the population is defined by the director of the facility having applied for a court order authorizing involuntary retention for a period of six months, one or two years. Since the MHISs are agencies of the courts it is not surprising that cases involving court action and possible judicial hearing receive high priority.

The First Department MHIS is somewhat different because that agency is responsible for the Bellevue Hospital caseload; the single largest (in psychiatric admissions) general hospital in the State. Within that sample, therefore, was the highest proportion of emergency admissions among the four departments. The medical staff appear to apply for court orders of retention for every emergency admission. Many of those cases are calendared for hearing and adjourned repeatedly and never go to hearing. This process artificially inflates the number of retentions to be reviewed and gives an incorrect impression of the First Department MHIS performance.

The required MHIS reviews of involuntary retentions of patients were most often carried out in the Second and Fourth Department MHISs. In the Second Department, 92 percent of the involuntary retention proceedings fell into the category "all reviews

Table 6

Completion of Retention Reviews of Involuntary Status Patients*

Rate of Completion of Retention Reviews	Judicial Department MHIS			
	First (n=49)	Second (n=64)	Third (n=26)	Fourth (n=59)
Cases with all retention reviews completed	33%	92%	73%	93%
Cases with some retention reviews completed	14	5	19	3
Cases with no retention reviews completed	53	3	8	3

*Each case can involve more than one retention review depending on how long the patient was kept on involuntary status.

Source: Compiled by LCER staff from data obtained from MHIS case files.

completed" compared to 93 percent of the cases in the Fourth Department. In the Third Department nearly three-quarters of the cases had all reviews completed with another 19 percent having at least some reviews completed. One-third of the cases in the First Department had all retentions reviewed. More than half had no reviews completed at all.

Annual reviews of suitability and willingness. In each MHIS at least some cases met the statutory requirement that the suitability (defined in law) and willingness of patients to continue on voluntary, informal, conditional release and non-objecting status be reviewed at least once every 12 months. However, in few cases were all required reviews completed. The proportions of cases in the "all reviews completed" category were--First Department, 8 percent; Second Department, 29 percent; Third Department, 4 percent; and Fourth Department, 5 percent (see Table 7). Including both cases with some or all reviews completed--First Department, 59 percent; Second Department, 87 percent; Third Department, 64 percent; and Fourth Department, 39 percent; significant portions of the population have no annual reviews done at all. As Table B-9 shows, in the Third and Fourth Departments the patients on conditional release--those with the most tenuous link to the hospital/developmental center--were the persons who had the highest proportions of cases with no reviews completed. In the First Department MHIS (Table B-7) the group with the highest proportion of cases with no reviews completed were those on voluntary or informal status.

Review of incident report. Review of all incident reports involving patients is one approach used by the MHISs to detect possible abuse and/or neglect. By reviewing all reports, certain kinds of patterns of abuse or neglect might be detected. In all but the Fourth Department the largest proportion of cases fell into the "no reviews completed" category (see Table 8). Of those cases which had incidents reported the Third Department had the highest average number of incidents per patient--ten. The Fourth Department had the lowest--four--as well as the largest proportion of cases with all reviews completed.

Table 7

Annual Reviews of Suitability and Willingness for Voluntary/Informal, Conditional Release and Non-objecting Patients*

Completion of Annual Reviews	Judicial Department MHIS First (n = 59)	Second (n = 136)	Third (n = 88)	Fourth (n = 133)
Cases with all reviews completed	8%	29%	5%	5%
Cases with some reviews completed	51	58	59	34
Cases with no reviews completed	41	13	36	61

*Each case can involve more than one annual review.

Source: Compiled by LCER staff from data obtained in MHIS case files.

Table 8

Review of Incident Reports*

Completion of Review of Incident Reports	Judicial Department MHIS First (n = 18)	Second (n = 69)	Third (n = 49)	Fourth (n = 33)
Cases with all reviews completed	11%	13%	8%	49%
Cases with some reviews completed	17	20	31	6
Cases with no reviews completed	72	67	61	45

*Each case can involve more than one incident review.

Source: Compiled by LCER staff from data obtained in MHIS case files.

The LCER file search found the MHISs to be ineffective in delivering some of the oversight services--mandated by the Legislature--to patients admitted to facilities for the mentally disabled. Admission reviews were not carried out; interviews with notice of rights were not provided and annual reviews of suitability and willingness of patients on voluntary, informal, non-objecting and conditional release status were frequently not done. The MHISs were most effective in carrying out reviews of retentions.

Adequacy of Performance of Mandated Functions

The analyses of data obtained by LCER staff from MHIS patient files indicates that a shift in functional orientation--away from the information service function and toward a legal advocacy service--has already taken place because a significant proportion of the mentally disabled population do not receive all of the protections to which they are entitled under State law.

LCER Survey of Judges

The purpose of the survey was to determine the judges' perception of the quality and usefulness of the information reports submitted to the courts by the MHISs in cases involving the mentally disabled.

Methodology

The nine question survey was sent to each of the 459 County Court, Supreme Court and Surrogate's Court Judges in the State. There were 66 judges in the First Department, 212 in the Second Department, 79 in the Third Department and 102 in the Fourth

Department. The overall response rate was 191 or 42 percent: 35 percent in the First Department; 35 percent in the Second Department; 63 percent in the Third Department; and 43 percent in the Fourth Department. Of those who responded, 97 or 51 percent of the judges had heard cases of persons served by the MHISs in 1982. In descending order of frequency the respondents heard cases on the following issues (each response could be selected more than once):

Admission, retention or transfer protests	76
Proceeding for the appointment of a committee, conservator or guardian	43
Requests for changes in conditions of confinement of incapacitated defendants or persons acquitted by reason of mental disease or defect	39
Objections to treatment	34
Appointment of MHIS as guardian ad litem	25

Of the 97 judges who heard cases, 89 received information reports in the form of memoranda of law from the MHISs. Of those, 88 responded to a question about whether the information reports of the MHISs provided the courts with non-partisan information about the patients' cases--91 percent saying yes and 8 percent saying no. Of the 88 responses 20 included open-ended comments. The majority of the comments--13 or 68 percent were positive, stating, for example, that the reports were:

--An excellent synopsis of pertinent information,

--Excellent,

--Detailed and thorough and informative in assisting the court,

--Valued by court, sufficient data on which to base a decision, and

--Balanced and addressed the relevant facts.

The six negative comments--32 percent--were that the reports were:

--So generalized as to be inadequate,

--Not sufficiently personalized,

--Adequate but not completely satisfying to the court,

--[Omitting] information adverse to patient release,

--All identical and of no value to the court,

--[In some cases] biased.

The legislation passed in 1964 called for the MHISs to help the judges having to hear cases involving the mentally disabled by providing them with background information about the

patient without regard to whether it would help or hinder the patient's legal case. Once the MHISs, as a result of administrative regulations, began direct representation of patients at hearings some critics--the Commission on Quality of Care For the Mentally Disabled (CQC), for example--said that when the MHISs represent patients in court (directly or indirectly) and submit information reports to the judge there is a conflict of interest. The MHISs solution has been to continue direct representation of patients (an administrative mandate) and to stop submitting information reports (a legislative mandate). Instead, a memorandum of law is submitted as part of the patient's legal brief, which contains only information which is not detrimental to the patient's case. One judge's comment summarizes the significance of the change in favor of legal representation "now as the advocate of the patient the MHIS views the judge as an adversary. The court has lost its independent 'eyes and ears'."

The respondents were asked to give their overall impressions of the information reports by rating their usefulness, timeliness, adequacy and appropriateness. The results were very favorable as shown below:

	Strongly Positive	Moderately Positive
Usefulness	56%	27%
Timeliness	63	27
Content Adequacy	54	28
Appropriateness of the data provided	55	33

Adequacy of State Representation

The judges were asked for their opinions on whether the MHISs' adversaries in judicial proceedings represent the State's interests adequately. Opposing the MHIS staff in judicial proceedings may be:

Private attorneys for the hospital.	Civil proceedings involving a "voluntary" (not for profit) general hospital or a psychiatric facility.
The hospital's counsel or the municipality's counsel.	A civil proceeding involving a city or other municipal general hospital.
The District Attorney or the Attorney General.	All criminal proceedings.
The Attorney General.	Civil proceedings involving State facilities.

The "yes" responses were 94 percent of the total and 15 of the judges included additional comments--six positive and nine negative. Among the nine judges making negative comments were a few who had responded yes to the original question. The comments below are representative:

--Attorney General (AG) often ill prepared,

--Adequacy varies; lack of funding to retain qualified psychiatric examiners inhibits the ability of the AG or the District Attorney (D.A.) to represent the State,

--The AG usually receives the file on the day of the hearing and is not prepared,

--MHIS urges discharge in every instance. Institution is represented by Assistant Attorney General with no knowledge of the case,

--Often the psychiatrist has no attorney representing him and the judge has to ask questions,

--Court must conduct examination.

The positive comments about the adequacy of representation of the State's interests were:

--The AG is excellent; fair and helpful to the court,

--Competent and professional work,

--With courtesy, fairness and definitive determination,

--The AG appeared every time,

--The State is well represented by the local Assistant D.A.

Activities Performed For the Court

Section 29.09 MHL, paragraph (b)4 is permissive. The judges were asked to identify the functions performed by the MHISs which are implied or permitted by this paragraph. A number of the responses identified legislative mandates stated in other parts of section 29.09 MHL. Of the 60 open-ended responses made to the LCER request 16 or 27 percent, fell into the legislative mandate category. There were 15 responses--25 percent, which spoke of legal representation of patients as flowing from this paragraph. The remainder of the answers referred to liaison, ombudsman and protective services as well as "services to the court."

General Open-ended Comments

With a few reservations about MHISs move away from the information agency role, the need for and value of the Mental Health Information Services was endorsed by the judges who responded to the LCER survey.

LCER Survey of OMH/OMRDD Facility Directors

LCER also conducted a survey of all OMH and OMRDD facility directors in the State to elicit their perceptions of whether the State's interests are protected in judicial hearings involving the mentally disabled. The survey contained four questions:

1. Who usually represents the State institution in judicial proceedings in which mentally disabled persons are represented by the Mental Health Information Services and/or Court appointed counsel?

2. In your opinion, is the State's legal representation at judicial hearings equal to that provided by MHIS?

3. In your opinion, are the interests of the State adequately represented?

4. What changes could be made to improve the existing method of representing the State's interests in judicial proceedings concerning the mentally disabled?

Surveys were sent to facility directors of 31 OMH facilities. Twenty-eight responses were received for a response rate of 90 percent. In the case of OMRDD, surveys were mailed to directors at 24 facilities and 12 responses were received (a response rate of 50 percent).

Who Usually Represents the State?

In response to this question, directors were offered four choices and requested to indicate all that applied:

--OMH/OMRDD psychiatrist/psychologist,
--OMH/OMRDD staff attorney,
--Staff of the Attorney General's Office,
--Other.

Table 9 presents data on the number of responses given in each category. Of the 12 OMRDD directors responding to this question, 83 percent indicated that staff of the

Table 9

Who Represents the State?[a]

Personnel	OMH (n = 28)	OMRDD (n = 12)	Total (n = 40)
OMH/OMRDD Psychiatrist/Psychologist	93%	42%	78%
OMH/OMRDD Staff Attorney	7	17	10
Staff of the Attorney General's Office	82	83	83
Other[b]	11	50	23

[a]Survey respondents were asked to check all categories that applied. Therefore, the number of responses exceeds the total number of survey respondents (n=40).

[b]For OMRDD, this category included institutional placement staff, social workers, chief of services, and independent psychiatrists appointed by the court. For OMH, this category included other clinical and administrative staff.

Source: LCER Survey of OMH/OMRDD Facility Directors, October 1983.

Attorney General's Office represented the State. In the case of OMH, the most frequent responses were the staff psychiatrist (93 percent) and staff of the Attorney General's Office (82 percent). Least often cited as representing the State facilities were the OMH (7 percent) and OMRDD (17 percent) attorneys.

Is the State's Representation Equal to That Provided by MHIS?

Eighty percent of responses by both OMH and OMRDD directors to this question was "yes" (see Table 10). Twenty-five percent of all respondents made additional positive comments about their representation, such as:

> --AG's office provides competent representation and cooperates and assists facility staff,
>
> --AAGs are usually more experienced lawyers than MHIS staff attorneys,
>
> --The legal representation both from our Attorney General's Office and the Mental Health Information Service has been of an extremely high calibre,
>
> --... the Asst. Attorney General ... who services [our] Center ... spends a great deal of time preparing staff to testify at court hearings....

This favorable response is tempered, however, by negative comments offered by 28 percent of all respondents (including 22 percent of those directors who responded "yes"). These statements citing the generalist background of the Attorney General's (AG) staff, its lack of familiarity with cases, and the lack of time for preparing cases suggest an inequality of representation.

Are the Interests of the State Adequately Represented?

Eighty percent of responses were positive (see Table 11). Eighty-six percent of those directors making positive comments indicated that coordination is key to adequate representation:

Table 10

Is the State's Representation Equal
To That Provided by MHIS?

Facility Type	Yes	No	Variable	(n =)
OMH	79%	18%	4%	28
OMRDD	83	17	—	12
Total	80%	18%	3%	40

Source: LCER Survey of OMH/OMRDD Facility Directors, October 1983.

Table 11

Are the Interests of the State
Adequately Represented?

Facility Type	Yes	No	Variable	(n =)
OMH	82%	14%	4%	28
OMRDD	75	25	--	12
Total	80%	18%	3%	40

Source: LCER Survey of OMH/OMRDD Facility Directors, October 1983.

--AG's Office works closely with us to make sure that we have the right representation with us to represent the patients,

--State is usually represented by a Board Certified Psychiatrist who knows the patients intimately and tries to work closely with the AAG and MHIS so that an adversative setting is usually avoided,

--Dialogues and working relationships have been established with the court system to insure understanding of our policy and procedure,

--They have shown improvement . . . State Attorneys have visited the hospital and have made themselves more available for conferences.

Negative comments offered by 35 percent of all respondents (including 22 percent of those directors who responded "yes") cited a lack of coordination between the facility and the Attorney General's staff:

--Those who legally represent the State often are not familiar with the planning pursued by the State,

--Assistant Attorney Generals [sic] usually meet with center staff in a hurried and last minute fashion and are thus inadequately prepared,

--When represented by the AG staff, communication is limited to a few questions of fact. Facility does not know what transpires unless a facility representative is present,

--Lawyers representing facility are not as aggressive as MHIS, State's lawyers act in a perfunctory manner. Not much interest in result,

--Better representation when OMRDD attorneys are present.

Suggestions For Improvement

Suggestions for improvement were offered by 65 percent of the facility directors. These suggestions centered on improving the deficiencies just cited. Improvements in

communication between the facility and the Attorney General's Office (42 percent) were noted along with training of facility staff to increase their understanding of courtroom procedures, testimony, and the rules of evidence (27 percent). Other suggestions called for a change in the structure of legal representation (15 percent) including establishing a group of attorneys within the AG's Office specializing solely in mental health law. Another facility director called for the appointment of a single OMH/OMRDD attorney for entire regions. These statements indicate a need to clarify who is responsible for legal representation and ensure some continuity in the assignments of legal staff.

Chapter Summary

● LCER samples of the MHISs' files revealed that many of the legislatively mandated functions, intended to protect the constitutional rights of persons admitted to facilities for the mentally disabled are not being performed:

--Review of admissions to assure due process could be documented in fewer than one-third of the sample cases of any Judicial Department MHIS;

--The required patient notice of rights interviews were not carried out in more than two-thirds of the sample cases in each Department;

--Mandated reviews of cases involving involuntary retention were carried out with much greater frequency. Three of the four MHISs reviewed at least some of the retentions in better than 90 percent of their cases;

--Annual reviews to determine the suitability and willingness of voluntary, informal, non-objecting or conditionally released patients to remain on those statuses were not done in 41 percent of the cases in the First Department; 13 percent of the cases in the Second Department; 36 percent of the cases in the Third Department; and 61 percent of the cases in the Fourth Department.

--The use of incident report review to detect patient abuse and mistreatment was not as effective as it might have been. Between 45 to 72 percent of the cases in the four judicial department MHISs had no reviews done.

● The LCER survey of judges determined that the respondents viewed the services provided by the MHISs very favorably. They stated, for example, that "the reports give an excellent synopsis of pertinent information," "the reports are detailed and thorough and informative in assisting the court," and are "balanced and addressed the relevant facts."

● Some judges said that they regretted the MHISs having abandoned the "information report" function in favor of the submission of "memoranda of law" as part of the legal briefs. One judge's comment summarizes this viewpoint, "Now as the advocate of the patient the MHIS views the judge as an adversary. The court has lost its independent 'eyes and ears'."

● Eighty percent of OMH and OMRDD facility directors believe that the adversary relationship between the facility representative and the MHIS staff is an equal one and that the State's interests are being adequately protected. Open-ended comments provided by some of the respondents, however, tempered this favorable response and indicated that representation could be improved through better communication and coordination between the facility and its legal representative.

III PROGRAM WORKLOAD

The workload of the Mental Health Information Services has been questioned for many years. The MHISs have presented the Legislature with data which documents their failure to provide critical services explicitly mandated in legislation. The MHISs claim that the reason for this has been an ever-increasing number of legislative mandates without a concomitant increase in staffing. MHIS workload, however, consists of two types of duties--those explicitly mandated in legislation and those made mandatory in administrative regulation. To date, the question of how the MHISs apportion their workload between these two types of duties has not been addressed. LCER's survey of workload answers this question.

This chapter reviews the program operation of the four MHISs, analyzes the workload measures of prior studies of the MHISs and presents an analysis of LCER's own survey of MHIS workload.

Program Operation

Each MHIS was requested to provide a listing of facilities for which it was responsible. The six types of facilities are presented in Table 12 and include:

--General and private hospitals: all voluntary, municipal, and private hospitals licensed to receive and/or treat psychiatric patients;

Table 12

Number of Facilities by Type
Within Judicial Department MHIS

Type of Facility	Judicial Department MHIS			
	First	Second	Third	Fourth
General and Private Hospitals	22	50	14	19
State Psychiatric Centers	5	13	4	9
State Developmental Centers	2	10	4	7
Correctional Facilities	0	11	5	2
Community Facilities	1	15	7	6
Community Residences and Family Care Homes	238	724	951	902

Source: Data supplied by the Mental Health Information Service in each Judicial Department, June 1, 1983.

--State psychiatric centers;

--State developmental centers;

--State and local correctional facilities;

--Community mental health facilities and private schools;

--Community residences and family care homes for the mentally and developmentally disabled.

For the most part, each MHIS focuses its activity on the first three types of facilities. The Second Department has the largest population and contains the greatest number of State facilities as well as general and private hospitals.

Much of the workload in the First Department is centered on general and private psychiatric hospitals. Included among these is Bellevue Hospital, a general hospital with the greatest volume of psychiatric admissions in the State. As the LCER sample on effectiveness indicates, Bellevue had a higher proportion of involuntary commitments than the largest general hospital in the Second Department. Involuntary commitments precipitate more court hearings, more reports to the court, and more legal representation than voluntary commitments.

The Fourth Department includes the largest number of State facilities located upstate. Among these is Central New York Psychiatric Center--one of two maximum security psychiatric facilities in the State which serves forensic patients. The Director of the Fourth Department MHIS noted that the legal work at this facility was significant enough to have an attorney work there exclusively.[1]

Legislative mandates require that the mentally disabled in community residences and family care homes be served. With regard to this population, which is primarily developmentally disabled, the MHISs generally have two legislatively mandated functions:

--to conduct annual reviews for suitability and willingness to remain on conditional release; and

--to investigate abuse and mistreatment and take legal action, when necessary, to protect residents.

In addition, under Article 77 MHL, the MHISs may be appointed to act as guardian ad litem in a conservatorship proceeding for a resident.

The performance of these functions is important since, as was demonstrated by conditions at the Willowbrook Developmental Center during the early 1970's, this is a population which is least able to protect itself. Residents in community facilities may be on conditional release from a State facility, may have been placed on discharge status or may have entered the community facility directly without ever having been placed in an institution. Although the MHISs stated that they view themselves as having responsibility for all persons placed in a community facility which has been given an operating certificate by OMRDD, they note that OMRDD disputes this view and limits MHIS action only to those patients on conditional release from a State facility. This has created a situation in which the MHISs in entering a given community residence would be allowed to address the needs of only some residents. In later written statements, however, the MHISs cite staffing shortages as limiting their services to those on conditional release.

Whatever the reason, all persons in community facilities today are not being served by the four MHISs.

Agency Structure

The four Mental Health Information Services have similar organizational structures and each MHIS has a departmental office which is the administrative office for the Judicial Department MHIS. These offices are located in major cities within their service areas. The departmental office for the First Department is in New York City; the Second Department's office is in Mineola; the Third Department's is located in Albany; and the Fourth Department's office is in Rochester. Departmental offices are staffed by the Director, Deputy Director, and administrative/clerical staffs.

Each MHIS maintains three district offices. In the Third Department, the departmental office in Albany also functions as a district office. District offices are administrative subdivisions of the central office and are usually headed by a Principal Attorney or a Principal Information Officer. Staffs located in other units throughout the district report to them. In the First and Second Departments, all their district offices are located in facilities which they serve. Bellevue Hospital, Manhattan Psychiatric Center and Bronx Psychiatric Center are district office sites in the First Department. In the Second Department, district offices are located at Creedmoor Psychiatric Center, Rockland Psychiatric Center and Pilgrim Psychiatric Center. In the Third Department, one of the district offices is located in the St. Lawrence Psychiatric Center. By placing these offices in facilities, MHIS staff and clients have greater access to each other.

For further comparison of organizational structure, LCER established definitions for two additional categories:

> Field offices: Offices located within facilities where MHIS staff maintain a regular physical presence. MHIS staff need not be present for the entire 35-hour week, but their visits must occur on a regularly scheduled weekly basis with the days and hours of MHIS staff availability known to staff and patients or residents of the facility.
>
> Satellite offices: Facilities which are the responsibility of MHIS but are visited less frequently, i.e., monthly, annually or as needed.

Table 13 presents the number of facilities at all levels within Judicial Department MHIS. The First and Second Department have more of their offices located in the facilities which they serve. The Third Department with a much greater geographic area and the smallest staff of the four departments, maintains no field offices.

Policy and Procedures

Using any reasonable measure of uniformity, it is clear that the MHISs do not have a common set of administrative guidelines establishing priorities and how the organizations will function. The rules and regulations of the four departments are similar; however, they do not establish priorities. Three MHISs maintain different procedure manuals--one did not maintain a procedure manual at all.

The JC-140 is a monthly workload document of each department. However, the documents required as back-up vary from a daily activity sheet in the First Department to an individual's handwritten notes in the Third Department.

Table 13

Units of Organization Within Judicial Department MHIS

Unit of Organization	Judicial Department MHIS			
	First	Second	Third	Fourth
Departmental Office	1	1	1	1
District Offices	3[a]	3[a]	2[b]	3
Field Offices	3[a]	17[a]	--	3[a]
Satellite Facilities	24	107	35	39
Community Residences and Family Care Homes[c]	238	724	951	902

[a] All office are located in State facilities or general hospitals.
[b] One district office is located in a State facility.
[c] A subset of Satellite Facilities.

Source: Developed by LCER staff from data supplied by each Judicial Department MHIS, June 1983.

In conducting fieldwork at each MHIS, it became clear that there is a lack of uniform procedures for keeping and using MHIS documents. MHIS forms and files such as the MHIS Interview Sheet and the MHIS Patient Record were used consistently by only one district in the Second Department. The recordkeeping in this district was exceptional because it was the single system which tracked the patient and clearly identified all the MHIS actions that had been completed. The absence of such a system in other MHIS offices affected their ability to support their reported workload and most importantly their ability to document that a patient's constitutional rights had been protected (see Chapter II).

In general, the MHISs maintained files for patients in State facilities but files were not maintained for general hospital patients unless court work was likely. The data most frequently maintained for general hospital patients consisted only of the admission forms plus the signed notice of rights forms which are not necessarily signed by the patient. In some cases, only the physician signs the form indicating that notice was given to the patient. There was no uniform procedure requiring MHIS staff to sign and date the papers upon review. In the Third Department MHIS, hospitals had been requested only to send copies of the signed notice-of-rights forms. Admission papers were retained at the hospital.

The MHISs have set no deadlines for how long the files (State facility and general hospital) must be retained. One result has been that in some MHISs papers, particularly those of voluntary admissions in general hospitals, were destroyed to make room for other files.

The MHISs have made much of the lack of file space. Yet, this problem relates primarily to the absence of administrative decisions on the type of documents to be retained and the length of time they must be held.

Staffing

The staffing found in each Mental Health Information Service reflects the geography and the number of institutions in the department and the individual Presiding Justice's philosophy. Early in MHIS history, the Presiding Justices in the First and Second Departments began hiring attorneys. This action opened the door for the MHISs' direct legal representation of patients/residents. The current staffing patterns, presented in Table 14, demonstrate the differences in downstate versus upstate MHISs. The Fourth Department is staffed primarily with information officers. The extent to which all departments intend to pursue the legal advocacy function is shown in the fact that requested increases in staffing for the last few years have been limited to increases in legal and clerical staff only. The MHISs are not requesting information officers and it is likely that this shift in staffing is for the provision of more legal advocacy functions.

As can be seen in Table 14, the Second Department has more staff positions than the other departments combined. It also has the highest number of clerical employees per professional staff member. In LCER fieldwork, the lack of clerical staff was cited as a reason for poor recordkeeping. However, even within the Second Department there were differences in recordkeeping. The one district within the Second Department which maintained excellent records was distinguished not by additional clerical staff but by a uniform procedure governing the use and retention of MHIS forms and documents.

Finance

Expenditure data for the last five fiscal years for each MHIS are presented in Table 15. Expenses not reflected in this table are for court-appointed counsel and/or psychiatrists under section 35 of the Judiciary Law (see Table 16). The court may appoint counsel to represent indigent persons in proceedings including commitment, retention and habeas corpus. The court also may appoint psychiatrists, certified psychologists or physicians to conduct examinations and testify at these hearings. The Fourth Department has the fewest attorneys and uses appointed counsel most often.

Section 35 appointments may be made at the request of MHIS or other interested parties such as the facility or the court itself. In reporting the data to LCER, the Office of Court Administration (OCA) was unable to distinguish which party in the proceeding had requested the appointment. Such specificity is required as an administrative check on costs because the party requesting services should be verifying that they were received to the extent of the reimbursement. Psychiatric services in the First Department in 1982-83 averaged $387 per appointment, an amount exceeding that called for in law, except in extraordinary circumstances.

> such compensation shall not exceed two hundred dollars if one psychiatrist, psychologist or physician is appointed, or an aggregate sum of three hundred dollars if two psychiatrists, psychologists, or physicians are appointed, except that in extraordinary circumstances the court may provide for compensation in excess of the foregoing limits.[2]

When contacted by LCER staff, First Department MHIS officials indicated that they had been unaware of the reimbursements paid by the Appellate Division. LCER staff has since been notified that the First Department MHIS is seeking to change at least the voucher format to specify which party in the proceeding requested the appointment.

Table 14

Number of Staff by Type Within MHIS
Judicial Department
1983

Type of Staff	Judicial Department MHIS			
	First	Second	Third	Fourth
Director and Deputy Director	2	2	2	2
Staff Attorneys	22	51	3	3
Information Officers	4	--	5	14
Clerical	11	46	6	10
Total	39	99	18	29

Source: Data provided by each Judicial Department MHIS in response to LCER request of November, 1983.

Table 15

Expenditures by Mental Health Information Service
FY 1978-79 through FY 1982-83

Fiscal Year	Judicial Department MHIS			
	First	Second	Third	Fourth
1978-79				
Personal Service	$ 691,193	$1,606,337	$321,137	$495,944
Non-Personal Service	35,096	162,213	25,133	79,634
Total	$ 726,289	$1,768,550	$346,270	$575,578
1979-80				
Personal Service	$ 771,608	$1,819,476	$358,340	$528,455
Non-Personal Service	43,214	155,656	31,094	77,901
Total	$ 814,822	$1,975,132	$389,434	$606,356
1980-81				
Personal Service	$ 848,969	$1,803,460	$375,517	$558,897
Non-Personal Service	37,900	155,085	35,264	81,767
Total	$ 886,869	$1,958,545	$410,781	$640,664
1981-82				
Personal Service	$ 843,480	$1,917,015	$406,873	$621,063
Non-Personal Service	57,101	190,249	47,409	101,865
Total	$ 900,581	$2,107,264	$454,282	$722,928
1982-83				
Personal Service	$1,006,436	$2,193,139	$460,569	$697,535
Non-Personal Service	65,231	186,635	42,959	114,874
Total	$1,071,667	$2,379,774	$503,528	$812,409

Source: Personal service expenditure data supplied by the Office of Court Administration, November, 1983; Non-personal service expenditure data from each Mental Health Information Service, November 1983.

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Table 16

Assignments to MHIS Clients
Pursuant to Section 35 of the Judiciary Law

	Judicial Department MHIS														
	First			Second			Third			Fourth			Totals		
	Appointed	Cost	Cost Per Appointment	Appointed	Cost*	Cost Per Appointment	Appointed	Cost	Cost Per Appointment	Appointed	Cost	Cost Per Appointment	Appointed	Cost	Cost Per Appointment
1978-79															
Attorneys	-0-	-0-	-0-	2	$ 300	$150	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Psychiatrists	24	$ 5,332	$222	195	39,000	200	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1979-80															
Attorneys	-0-	-0-	-0-	4	600	150	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Psychiatrists	9	2,040	227	233	46,600	200	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1980-81															
Attorneys	-0-	-0-	-0-	8	1,200	150	24	$1,890	$ 79	605	$63,431	$105	637	$ 66,521	$104
Psychiatrists	33	10,425	316	298	59,600	200	27	2,545	94	485	79,505	164	843	152,075	180
1981-82															
Attorneys	-0-	-0-	-0-	12	1,800	150	9	434	48	529	71,015	134	550	73,249	133
Psychiatrists	36	11,205	311	301	60,200	200	20	1,953	98	529	86,195	163	886	159,553	180
1982-83															
Attorneys	-0-	-0-	-0-	12	1,800	150	32	2,509	78	578	73,021	126	622	77,330	124
Psychiatrists	30	11,610	387	249	49,800	200	46	5,652	123	457	73,156	160	782	140,218	179

*Estimated Expenses

Source: Data from the Office of Court Administration, November 1983.

Such specificity is also necessary to determine, for example, to what extent the use of court appointed private attorneys leads to the use of private psychiatrists because the attorneys are less familiar with this field. The Fourth Department MHIS claimed that private attorneys less familiar with this area of mental health law often request the appointment of a private psychiatrist. If the Fourth Department MHIS hired more staff attorneys, then, it asserts the cost of Section 35 psychiatric as well as legal appointments would decline. However, the number of psychiatric appointments in the Second Department MHIS, which has a professional staff of attorneys only, contradicts this assertion.

Prior Studies of MHIS Workload

There have been two prior studies of MHIS workload. The first was conducted in 1977 at the request of the Legislature. At that time, the MHISs had requested a staffing increase of 27 persons and the Legislature was seeking more specific information on staffing requirements. That study, conducted by the Office of Court Administration, involved a brief survey of the MHISs in which various tasks reflecting both mandated and non-mandated functions were aggregated into seven general categories. Average time to accomplish that task were then established for each category. Annual workload projections were based on data submitted by the MHISs and the Department of Mental Hygiene. After multiplying the projected workload by the average time, the study found that MHIS staffing needs would be almost three times what had been requested. This study did not attempt to distinguish functions which were legislatively mandated from those that were administratively mandated since all functions were given equal weight.

In 1980 the Commission on Quality of Care for the Mentally Disabled (CQC) published a review of MHIS. Its report took at face value the workload information reported by the MHISs and OCA:

> According to workload figures supplied by the Office of Court Administration, for the current fiscal year MHIS will fail to serve 43 percent of patients admitted to mental hospitals, will fail to review the status of over half of the voluntary patients as required by law, and will fail to serve approximately three-quarters of the patients released or transferred from mental hygiene facilities.[3]

In making its recommendations, CQC, like OCA, did not examine MHIS workload in terms of legislative intent. Instead CQC found that "the functions of MHIS should be streamlined so that the agency primarily is responsible for legal/advocacy services."

Part of the 'streamlining' which CQC recommended was the elimination of the patient abuse and mistreatment investigations by MHIS. However, MHIS is the only full-time independent agency charged with this function. The Boards of Visitors for each State facility are independent agencies but they usually meet only monthly or bi-monthly. Other agencies charged with abuse investigation--CQC, OMH, OMRDD--are part of the Executive Department and their independence may be in question. The MHISs are the only agencies which, on their own, can initiate legal action. Further, since MHIS staff are frequently located in facilities they are most likely to be aware of abuse and can follow-up with facilities to assure that steps are taken to prevent abuse.

JC-140

The Mental Health Information Services record workload data on form JC-140. This form was designed by the MHISs and, therefore, can be considered to reflect their

programmatic and service priorities. Over three-fourths of this form is devoted to tracking judicial proceedings and results. On one side, under the heading 'Other Matters', is an undifferentiated listing of legislatively mandated and administratively mandated activities. No emphasis or priority is assigned actions explicitly called for in legislation. Because of the MHISs failure to distinguish between workload performed as a result of a legislative or administrative mandate, it cannot be determined whether their requests for additional staff were created by legislative mandates as they have claimed in their budget requests. As will be shown, organizing and relating workload data to legislative intent is vital to management of the MHIS.

LCER Workload Survey

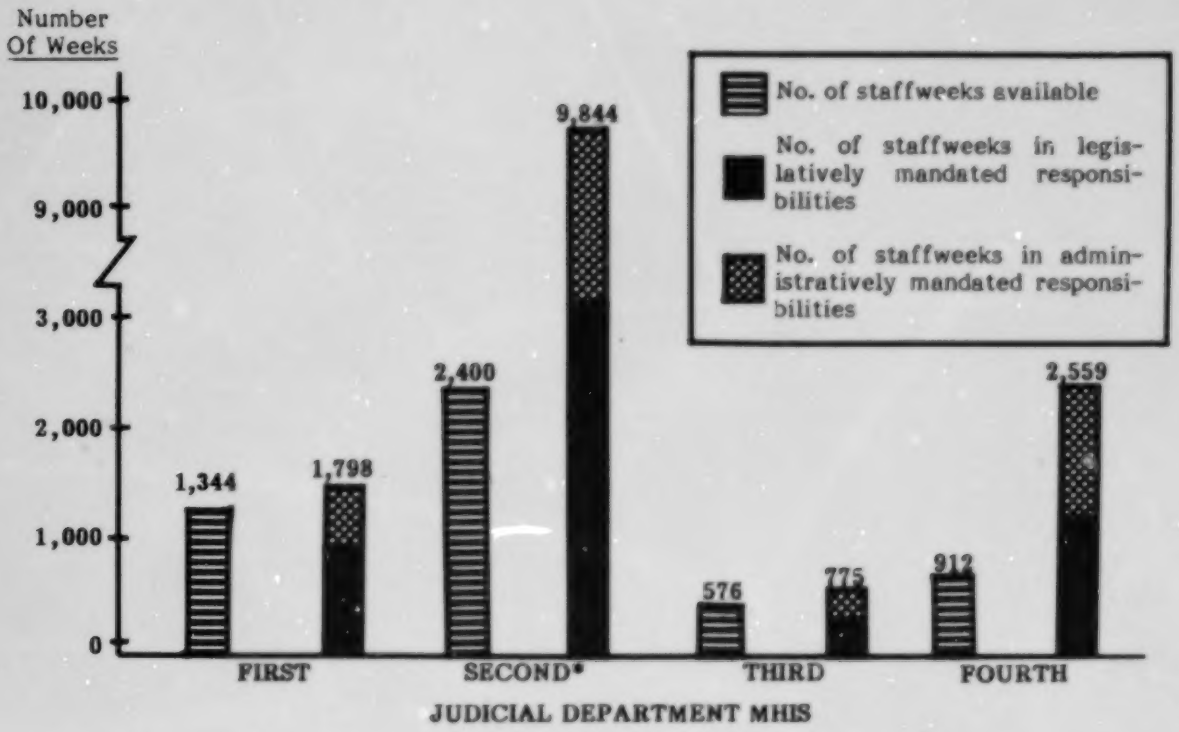
LCER's survey provided the MHISs with an opportunity to define their 1982 workload in terms of legislative intent. Explicit mandates of Section 29.09 of the Mental Health Law and other relevant statutes were cited and each MHIS was requested to provide data on the number of times the function was performed, the personnel involved, the average time needed to perform the function and the source of the MHISs' data. In addition, each MHIS was requested to list functions performed as a result of administrative mandate, i.e., those required by a judge and pursuant to the regulations of the Presiding Justice.

Citing Section 29.09 MHL, each MHIS was asked to provide LCER staff with the number of admission and retention reviews, interviews with patients and/or families notifying them of their rights, and information reports provided to the court during 1982. The MHISs responded using data from their principal internal management document--the JC-140. This document does not track workload strictly in terms of intent. Thus, in responding to the LCER survey, the MHISs altered the request to reflect data already being collected. Admission reviews became the total of admission and transfer reviews; the number of retention reviews was taken from the number of applications filed; and the number of notice-of-rights interviews was altered to include "all interviews with patients, hospital and outside support personnel, family, friends, etc. whether or not related to a judicial proceeding." By citing the JC-140 and providing such all-inclusive categories the MHISs showed their inability to track workload in terms of intent. Such tracking is necessary because it provides a benchmark against which the the MHISs can measure their progress in meeting legislative mandates. And with such knowledge the MHISs can then make decisions about the use of staff for mandated and non-mandated activities. The need for such information is further supported by LCER's effectiveness sample which found that the vast majority of clients of all statuses were not being interviewed by MHIS at all.

In analyzing the MHISs' responses to the survey, LCER staff multiplied the number of times a given function was performed by the average time needed. Functions were classified as either legislative mandates or administrative mandates. As noted earlier, LCER staff had listed the legislative mandates while the MHISs listed the administratively mandated activities. A figure representing the total staffweeks of workload reported in 1982 was then calculated and compared to the number of staffweeks available during 1982. Included in this latter figure was the time for each professional staff member for 35 hours a week, 48 weeks a year. Supervision and travel time was subtracted from the total staffweeks available in the First, Third and Fourth Department MHIS's since they had provided the data. As demonstrated dramatically in Chart 1 the total staffweeks of workload reported in 1982 exceed the number of staffweeks available. The reason for this may stem from two factors. First, the MHISs did not provide average times per function. They provided ranges of time instead and the mid-point of these

Chart 1

Number of Staffweeks Available and Worked On Legislatively Mandated and Administratively Mandated Responsibilities By MHIS Department
1982



*No reduction for supervision or travel.

Source: LCER survey of MHIS Workload, November 1983.

ranges was substituted by LCER staff for the average. Second, the number of activities reported may not be correct. Workload reporting in the areas of admission, transfer and retention reviews apparently is based on the assumption that all papers received by the MHISs are reviewed. The LCER staff effectiveness survey of MHISs' files, however, proves this assumption is incorrect.

LCER's survey of workload is useful in determining how the MHISs allocated their 1982 workload activities between legislative mandates and administrative mandates. Legislatively mandated activities included: admission (transfer) and retention reviews, notice of rights interview (all non-judicial contacts with mental patients and residents), information reports to the court, suitability and willingness reviews, incident report reviews and abuse investigations. As presented in Table 17, for each of the four MHISs these activities represented less than 34 percent of the total number of workload staffweeks reported for 1982. In fact, these percentages may be even less since the MHISs were unable to fully distinguish legislatively mandated activities.

Table 17

Percentage of Time Spent On Legislative and Administrative Activities In Each Judicial Department MHIS
1982

Activity	Judicial Department MHIS First	Second	Third	Fourth
Legislatively mandated functions[a]	32.4%	24.7%	34.2%	27%
Administratively mandated functions[b]	67.6	75.3	65.8	73
Advocacy services	40.0%	47.6%	24.8%	40.6%
Legal representation of patients	12.3	9.2	11.8	11.0[c]
Review of hospital charts	11.5	7.8	11.2	14.7
Information services	3.7	10.7	17.3	6.4
Liaison with Board of Visitors	.02	.1	.6	.4

[a] Percentages may be inflated due to the fact that the MHISs were unable to fully distinguish legislatively mandated activities.
[b] Discrepancy results from rounding of numbers.
[c] As reported by the Fourth Department, this category also included attendance at hearings.

Source: LCER Survey of MHIS Workload, November 1983.

Table 17 also breaks down the administrative mandate category into the five major activities which the MHISs perform: advocacy services, legal representation of patients, review of hospital charts, information services and liaison with Boards of Visitors.

Advocacy services are defined as "intercessions made on behalf of a patient with someone within or outside of the institution." Examples of this, provided in the handbook of the First Department MHIS include: discussing the patient's desire to leave the facility with his physician; reporting to an administrator that a ward is not sufficiently heated; or contacting a landlord or friend to determine if a patient could live there after discharge. Each separate action is reported as an advocacy service. Therefore, a letter and a telephone call to the same person on behalf of the same patient is counted as two advocacy services. Advocacy services account for the largest percentage of time spent on any legislative or administrative activity in 1982.

In the First and Second Departments, the legal representation of patients including administrative appeals of treatment plus advocacy services accounted for more than 50 percent of total workload staffweeks reported for those departments in 1982. The Third Department MHIS reported a lower percentage of workload in advocacy services yet reported a higher percentage of information services which provide general information about legal matters to non-institutionalized persons. In the Fourth Department, the provision of advocacy services and the review of hospital charts comprised the largest percentage of total workload staffweeks.

The Fourth Department MHIS reports spending a greater proportion of time in legal representation than does the Second Department MHIS which has a professional staff of attorneys only. This is because the Fourth Department included in their figures the attendance of MHIS officers assisting at hearings. Also included in this percent, are 39 staffweeks of time reported by the Fourth Department MHIS in obtaining services of attorneys and psychiatrists pursuant to Section 35, Judiciary Law.

LCER's survey of effectiveness demonstrated that the MHISs are failing to provide basic constitutional guarantees mandated in legislation to the majority of mentally disabled persons in the State. LCER's survey also established that the MHISs do not maintain workload data in a way which would allow them to be aware of the extent of non-compliance. By maintaining workload data in terms of legislative mandates the MHISs would have a benchmark against which they could measure their progress and make decisions about the most effective deployment of staff. The need for such management information is demonstrated by the analysis of the proportion of MHIS 1982 workload devoted to fulfilling legislative and administratively mandated activities. Over two-thirds of the 1982 MHIS workload stemmed from their administrative mandates and not legislative mandates.

There are few legislative mandates on the MHISs. Those that exist are central to protecting the rights of the mentally disabled. A program bill submitted by the Governor during the 1983 legislative session (S-6335) would have formalized the de facto shift in MHIS functioning. The fact that it was considered necessary to introduce such legislation supports the LCER finding that the law does not now include direct legal representation of patients other than in abuse cases. Before legitimizing the existing MHIS situation in law it should be considered that to date the MHISs' emphasis on advocacy services and legal representation appears to have taken priority over the provision of legislatively mandated protections for individuals. Furthermore, one of the bulwarks of the constitutionality of the New York State system of institutionalization of the mentally disabled is the MHISs' oversight.

Legislative action has added to the MHISs' workload but only in the area of patient abuse has legal representation been mandated. Whatever workload flows from any other legal advocacy activities is one the MHISs have chosen to take on. The requirement that information services be provided to patients and the courts has not been modified, and should not be subordinated to functions not explicit in law.

Chapter Summary

● The MHISs do not track workload in terms of legislative mandates. As a result, they are unaware of the extent to which they fail to provide basic constitutional protections to their clients expressly called for in State law.

● Previous studies of the MHISs by the Office of Court Administration and the Commission on the Quality of Care for the Mentally Disabled did not link MHIS workload to legislative intent and the specific legislative mandates established in law.

● Analysis of 1982 MHIS workload indicates that over 65 percent of the effort expended in any one department MHIS was devoted to fulfilling administrative mandates rather than legislative mandates.

● There are no uniform statewide policies and procedures established regarding the recording and maintenance of MHIS documents. As a result, MHIS Departments are unable to support their reported workload but most importantly, they are unable to document that a patient's constitutional rights have been protected. The fact that accurate records can and should be maintained is exemplified by the fact that in one district within the Second Department MHIS activities were properly documented.

● Differences among the four MHISs in service area, agency structure and staffing pattern do not appear to affect the distribution of workload between legislative and administrative mandates.

● A shift in philosophy and function is taking place away from the information agency purposes originally intended when the MHISs were created by Chapter 738 of the Laws of 1964. Through administrative rules and regulations legal/advocacy services have been made a central function of the four MHISs. The information agency functions of the MHISs, specified in law, which help preserve the constitutionality of the New York State system of institutionalization of the mentally disabled are being supplanted by its legal/advocacy activities.

FOOTNOTES

I. Introduction

1. David B. Guralnik, Editor in Chief, Webster's New World Dictionary of the American Language, 2nd Edition (New York: , Simon and Schuster 1980), p. 860. Black's Law Dictionary, (St. Paul, Minnesota: West Publishing Company, 1979), p. 867.
2. Association of the Bar of the City of New York and Cornell Law School, Mental Illness and Due Process, (Ithaca: Cornell University Press, 1962), p. 15.
3. Ibid., p. 20.
4. Ibid., p. 4.
5. NYS Legislative Annual, "Memorandum of the Association of the Bar of the City of New York, Special Committee to Study Commitment Procedures", 1964, p. 329.
6. Ibid., p. 521.
7. NYS Division of the Budget "Budget Report On Bills, S2605, A 4219," Session year 1964, p. 2.
8. Chairman of the Committee on Mental Hygiene, New York State Bar Association "Testimony at Public Hearings to Amend the Mental Hygiene Law."
9. Simon Rosenzweig, "A Review of Rules and Regulations: Mental Health Information Service," New York Law Journal, April 18, 1975, pp. 1, 4.

III. Program Workload

1. Response of the Fourth Judicial Department MHIS to LCER Survey of MHIS Workload, November 1983.
2. Judiciary Law, Section 35.
3. Hearings of the Senate Committee on Mental Hygiene and Addiction Control, Testimony of the Chairman, Commission on Quality of Care for the the Mentally Disabled, January 12, 1982.

APPENDIX A

INTERVIEWS AND CONTACTS

Appellate Division of the Supreme Court

Office of Court Administration

Deputy Chief Administrator, Director of Budget and Finance, Associate Budget Analyst, OCA Regional Budget Officer

Appellate Division, First Judicial Department

Principal Appellate Court Clerk

First Judicial Department, MHIS

Director, Deputy Director, Administrative Assistant, Associate Attorney, Associate Attorney, Principal Attorney

Second Judicial Department, MHIS

Director, Deputy Director; Principal Attorney, Tenth District Office; Principal Attorney, Second and Eleventh District Office

Third Judicial Department, MHIS

Director, Deputy Director

Fourth Judicial Department, MHIS

Director, Deputy Director; Principal Officer, Rochester District Office; Principal Officer, Utica District Office

Executive Agencies

Office of Mental Health

Director, Bureau of Statistical Analysis

Office of Mental Retardation and Developmental Disabilities

Assistant Director, Bureau of Information Services; Supervisor, EDP

Commission on Quality of Care for the Mentally Disabled

Chairman, Counsel, Program Research Specialist

APPENDIX B

LCER SAMPLE OF MHIS FILES

Sample Methodology

In gathering data on the population to be served by the MHISs, a number of factors concerning the MHISs' responsibilities were taken into consideration--the different types of population (mentally ill and mentally retarded); the different types of facilities (State facilities, general and private hospitals, community residences); different legal statuses of the population (voluntary, involuntary and non-objecting); and the varying lengths of stay of the population (patients in State facilities generally experience longer stays and are to have their statuses reviewed annually by the MHISs). MHIS files were not consistently maintained and could not serve as a data base. LCER staff, with the assistance of OMH and OMRDD personnel, selected the sample on the best information available. Data on the OMH and general hospital population were obtained from census information provided in a cross-sectional study conducted in one week during November-December 1981. This study, which provided data on the numbers served at those facilities during that week, was chosen since it provided a uniform base from which to select a sample of psychiatric patients. A similar data base was created for the OMRDD population. Information from each of these data bases was reported by county. LCER staff aggregated the data based on the geography of each of the four Mental Health Information Services. Separate samples were drawn for each MHIS based on the total number of OMH and OMRDD clients in that department. (Selection of the general hospital population is described below.) Individual department samples were stratified for key characteristics such as the type of facility and the legal status of the clients. Each case file was documented on the basis of a single admission. That is, only data from the admission which fell into the sample time frame were used. Prior and subsequent admissions were not included.

Table B-1 compares the total OMH and OMRDD population to the sample. The sample was designed to achieve a confidence level of 90 percent $\pm$ 7. Where sample size is smaller than planned it is because the MHISs were unable to provide the data on individual files selected.

As noted above, data on the number of patients served in general hospitals was also selected from the OMH 1981 cross-sectional study. LCER selected the general hospital with the largest population served in each Department MHIS. Sample size was determined based on the number of patients reported served during the study period by the four general hospitals. Data on the sample size were then applied to the current population because of the rapid turnover of patients plus the fact that at two of the MHISs data on general hospital patients were either inaccessible or had been discarded. It was assumed that the number of patients served would remain fairly consistent from year to year. While inferences cannot be drawn beyond the specific hospital selected for the sample to the general hospital population at large, the hospital populations were significant in and of themselves, representing from 12 percent in the Second Department to 20 percent in the First Department of the total general hospital population (private hospitals were excluded) served during the period covered by the OMH cross-sectional study.

Table B-1

Comparisons of OMH/OMRDD Population to Sample

By Type of Facility

	First Department		Second Department		Third Department		Fourth Department	
	Universe	Sample	Universe	Sample	Universe	Sample	Universe	Sample
Total State Facility Population								
OMH Patients	73.5%	53.9%	59.3%	56.7%	42.1%	41.9%	49.6%	48.6%
OMRDD Patients	26.5	46.1	40.6	43.3	57.9	58.1	50.4	51.4
(n =)	(3,252)	(102)	(26,668)	(164)	(5,737)	(136)	(12,069)	(175)

By Legal Status*

	First Department		Second Department		Third Department		Fourth Department	
	Universe	Sample	Universe	Sample	Universe	Sample	Universe	Sample
Total State Facility Population								
Voluntary Status	65.0%	51.0%	41.1%	45.7%	47.0%	57.4%	36.9%	43.4%
Involuntary Status	16.5	15.7	27.7	25.6	17.5	16.2	28.0	22.9
Non-Objecting Status	18.5	32.4	31.2	29.3	35.5	26.5	35.0	32.6
(n =)	(3,257)	(102)	(25,851)	(164)	(4,906)	(136)	(11,189)	(175)

*Of OMH and OMRDD patients as of November-December 1981.

Source: Developed by LCER staff.

Table B-2

Involuntary Status Admissions Reviewed
In Each Judicial Department MHIS
1981 and 1982-83 Samples[a]

MHIS Facility Type	Involuntary Admissions[b] Reviewed Yes	No	(n =)
First Department			
OMH	51%	49%	43
OMRDD	--	--	--
General Hospital	13	87	75
Total	27%	73%	118
Second Department			
OMH	64%	36%	33
OMRDD	100	--	2
General Hospital	11	89	9
Total	55%	45%	44
Third Department			
OMH	57%	43%	21
OMRDD	--	100	2
General Hospital	--	100	22
Total	27%	73%	45
Fourth Department			
OMH	38%	62%	32
OMRDD	50	50	2
General Hospital	14	86	42
Total	25%	75%	76

[a] 1981 sample applies to OMH and OMRDD population; 1982-83 sample applies to general hospital population; for complete explanation see methodology section in Appendix B.

[b] Includes Forensic cases; excludes "Old Law" admissions and cases marked "not applicable" or "no data."

Source: Compiled by LCER staff from data obtained from MHIS files.

Table B-3

Voluntary Status Admissions Reviewed
In Each Judicial Department MHIS
1981 and 1982-83 Samples[a]

MHIS Facility Type	Voluntary Admissions[b] Reviewed Yes	No	(n =)
First Department			
OMH	50%	50%	10
OMRDD	27	73	11
General Hospital	5	95	20
Total	22%	78%	41
Second Department			
OMH	89%	11%	18
OMRDD	33	67	13
General Hospital	2	98	87
Total	19%	81%	118
Third Department			
OMH	21%	79%	14
OMRDD	4	96	26
General Hospital	--	100	42
Total	5%	95%	82
Fourth Department			
OMH	--	100%	13
OMRDD	--	100	14
General Hospital	--	100	44
Total	--	100%	71

[a] 1981 sample applies to OMH and OMRDD population; 1982-83 sample applies to general hospital population; for complete explanation see methodology section in Appendix B.

[b] Includes voluntary, informal and minor voluntary cases; excludes "Old Law" admissions and cases marked "not applicable" or "no data."

Source: Compiled by LCER staff from data obtained from MHIS files.

Table B-4

Non-Objecting Status Admissions Reviewed
In Each Judicial Department MHIS
1981 Sample

MHIS Facility Type	Non-Objecting Admissions* Reviewed Yes	No	(n =)
First Department OMRDD	16%	84%	19
Second Department OMRDD	36	64	11
Third Department OMRDD	--	100	17
Fourth Department OMRDD	13	88	24

*Excludes cases "not applicable" and "no data"; excludes "Old Law" admissions.

Source: Compiled by LCER staff from data obtained from MHIS files.

Table B-5

Notice of Rights Interview For All
Admissions Sampled[a] In Each Department MHIS
1981 and 1982-83 Samples[b]

MHIS	Notice of Rights Interview Yes	No	(n =)
First Department	12%	88%	190
Second Department	26	74	182
Third Department	5	95	173
Fourth Department	6	94	177
Total	12%	88%	722

[a]Excludes 198 Old Law cases.

[b]1981 sample applies to OMH and OMRDD population; 1982-83 sample applies to general hospital population; for complete explanation see methodology section in Appendix B.

Source: Compiled by LCER staff from data obtained in MHIS case files.

Table B-6

Notice of Rights Interview For All Admissions Sampled[a]
In Each Department MHIS By Type of Facility
1981 and 1982-83 Samples[b]

Type Of Facility	Notice of Rights Interview Yes	No	(n =)
OMH	36%	64%	196
OMRDD	7	93	183
General Hospital	2	98	343
Total	12%	88%	722

[a] Excludes 198 Old Law cases.
[b] 1981 sample applies to OMH and OMRDD population; 1982-83 sample applies to general hospital population; for complete explanation see methodology section in Appendix B.

Source: Compiled by LCER staff from data obtained from MHIS files.

Table B-7

Annual Reviews of Suitability and Willingness of
Patients on Voluntary/Informal Status--Excluding
Patients on Conditional Release[a]
1981 and 1982-83 Samples[b]

Rate of Completion of Annual Reviews n = cases	Judicial Department MHIS First n =22	Second n = 70	Third n = 36	Fourth n = 54
Cases with all reviews completed	5%	33%	9%	4%
Cases with some reviews completed	18	56	64	37
Cases with no reviews completed	77	11	25	59

[a] Each case can involve more than one annual review.
[b] 1981 sample applies to OMH and OMRDD population; 1982-83 sample applies to general hospital population; for complete explanation see methodology section in Appendix B.

Source: Compiled by LCER staff from data obtained in MHIS case files.

Table B-8

Annual Reviews of Suitability and Willingness of
Patients on Non-objecting Status*
1981 Sample

Rate of Completion of Annual Reviews n = cases	Judicial Department MHIS First n = 23	Second n = 45	Third n = 17	Fourth n = 55
Cases with all reviews completed	13%	27%	--%	7%
Cases with some reviews completed	70	62	94	45
Cases with no reviews completed	17	11	6	47

*Each case can involve more than one annual review.

Source: Compiled by LCER staff from data obtained in MHIS case files.

Table B-9

Annual Reviews of Suitability and Willingness of
Patients on Conditional Release[a]
1981 and 1982-83 Samples[b]

Rate of Completion of Annual Reviews n = cases	Judicial Department MHIS First n = 14	Second n = 21	Third n = 35	Fourth n = 24
Cases with all reviews completed	7%	24%	--%	--%
Cases with some reviews completed	71	57	37	4
Cases with no reviews completed	21	19	63	96

[a] Each case can involve more than one annual review.
[b] 1981 sample applies to OMH and OMRDD population; 1982-83 sample applies to general hospital population; for complete explanation see methodology section in Appendix B.

Source: Compiled by LCER staff from data obtained in MHIS case files.

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APPENDIX C

Classification of Sections of Law By Whether They Require or Mandate Action by the MHISs; Permit the MHISs To Act at Their Discretion; Require or Mandate Action by Another Agency

Exhibit C-1

Mandated Actions Required By MHISs	Discretionary Actions Permitted By MHISs	Mandated Actions Required By Other Agencies
Mental Hygiene Law		
Article 9: Hospitalization of the Mentally Ill Article 15: Admission of the Mentally Retarded to Schools; [Section of Law]		
		Facility director to notify patient of availability of MHISs [§9.07; 15.07]
		Facility director to notify MHISs of admission/conversion of status of minor. [§9.07; 15.07]
	Minor transfer without prior consent; MHISs given charge to see patient and review transfer [§9.09; 15.09]	
		Facility director to notify MHISs of minor's release/transfer [§9.09; 15.09]
		Facility director to send patient record to MHISs at admission (excludes informal and emergency admissions) [§9.11; 15.11]
	MHISs may ask for release of voluntary minor; if refused by facility director MHISs may apply to court for release [§9.13; 15.13]	
		Copy of voluntary/informal notice sent to MHISs [§9.19; 15.17]
		Notice of conversion of patient from involuntary to voluntary status to MHISs [§9.23; 15.21]
MHISs to review suitability/willingness of voluntary/informal status annually. MHISs to get court order settling the issue when necessary [§9.25; 15.23]		
		Give notice to MHISs of transfer of involuntary patient [§9.27; 15.27]
		Written notice of two physician certificate involuntary admission [§9.29; 15.29]
	MHISs may raise issue (request hearing) of need for involuntary care and treatment [§9.31; 15.31]	
		Facility director to send MHISs copy of request for hearing/record; court to notify MHISs of date of hearing [§9.31; 15.31]
		Notice to MHISs of retention application [§9.33; 15.33]
	MHISs may request hearing re: retention [§9.33; 15.33]	
		Immediate notice to MHISs of emergency admission [§9.39]
	MHISs may request hearing on issue of need for emergency observation [§9.39]	

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Exhibit C-1

Mandated Actions Required By MHISs	Discretionary Actions Permitted By MHISs	Mandated Actions Required By Other Agencies
MHISs to see juvenile delinquents admitted to OMH/OMRDD facility [§9.49; 15.37]		
	MHISs may request release of non-objecting patient [§15.25]	
		MHISs to be notified of non-objecting admission. [§15.25]
Annual review of non-objecting admission/retention [§15.25]		
Article 21 Alcoholism Facilities [§Section of Law]		
	MHISs to be available to minors in alcoholism facilities [§21.11]	
Article 29: General Provisions Relating to In-patient facilities		
Study and review of all admissions and retentions [§29.09]		All mental hygiene facilities must give the MHISs access to any part of the facility and data or information necessary to carrying out its services, functions, powers and duties. [§29.09]
Inform patients and others of procedures, rights to hearing, review, representation, other medical opinion [§29.09]		
Provide information reports to the courts: patient's case, hospitalization right to discharge, need for appointed counsel/psychiatrist [§29.09]		
	Provide services and assistance to patients, their families, the courts as the judge or justice of the court requires and in accordance with the regulations of the presiding justice of the appellate division of each judicial department [§29.09]	
Investigate abuse and mistreatment; take legal action (including representation) to protect patients [§29.09]		
		Copy of 120 day notice to conditionally released patients is to be sent to the MHISs [§29.15]
MIHSs to review suitability and willingness of conditionally released patients every 12 months [§29.15]		
		Facility director to notify MHISs of return to facility of involuntary patient on conditional release [§29.15]
	MHISs may request hearing within 30 days of involuntary patient's return to facility from conditional release [§29.15]	
	Copies of annual client service reports may be requested by MHISs [§29.18]	
		MHISs to be notified of availability of client service reports [§29.18]
Article 77: Conservators		
	In conservator proceedings MHISs have right to be heard when conservatee is in mental hygiene facility [§77.01]	

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Exhibit C-1

Mandated Actions Required By MHISs	Discretionary Actions Permitted By MHISs	Mandated Actions Required By Other Agencies
		Notice of conservator petition to be served on MHISs [$77.07]
MHISs to act as guardian ad litem in conservator proceeding, if assigned by judge [$77.07]		
		Notices re: restraining order involving conservator petition to be given to MHISs [$77.08]
		Copy of intermediate or final accounting to be given to MHISs [$77.31]
Article 78: Committee of Incompetent or Patient		
		Notice of petition to appoint a committee to be served on MHISs [$78.03]
MHISs to investigate facts and report to court re: suitability of appointment of committee [$78.07]		
Criminal Procedure Law		
Article 330: Proceedings From Verdict to Sentence		
		Clerk of court to forward examination order to MHISs [$330.20]
	MHISs may participate in all proceedings after receiving copy of exam order [$330.20]	
		MHISs to receive copies of exam reports [$330.20]
		MHISs to receive notices of applications to retain patient [$330.20]
	MHISs may demand hearing on issue of retention [$330.20]	
		MHISs to receive notice of application for: furlough order, transfer order, release order, discharge order, recommitment order [$330.20]
	MHISs may as "party to proceedings" to determine present mental condition, request additional psychiatric examiners [$330.20]	
Article 730: Mental Disease or Defect Excluding Fitness to Proceed		
		Notice to MHISs of applications to retain defendant [$730.50]
	MHISs may demand hearing on issue of retention [$730.50]	
		Facility director must notify MHISs of admission of defendant [$730.60]
Correction Law		
Article 16: State Hospitals for the Mentally Ll in the Department of Correction		
		MHISs to receive copies of notice, petitions and exam certificates when court order committing inmate is applied for [$402]
MHISs to provide notice of rights and admission procedures to inmates [$402]		

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Exhibit C-1

Mandated Actions Required By MHISs	Discretionary Actions Permitted By MHISs	Mandated Actions Required By Other Agencies
		MHISs to have personal access to inmate [§402]
		MHISs to receive notice of retention [§402]
	MHISs may request hearing re: need for retention [§402]	
		In emergency inmate can be transferred first with hearing after (to Central N.Y. Psychiatric Center) [§402]
Surrogate's Court Procedure Act		
Article 17: Guardians and Custodians Article 17-A: Guardians of Mentally Retarded Persons		
		Notice of petition to appoint guardian, for retarded person in a facility to be served on MHISs [§17.05]

Source: *Compiled by LCEK staff from McKinney's Consolidated Laws of New York Annotated: 10 B-Correction Law; 11 A Criminal Procedure Law; 34A Mental Hygiene Law; 58A Surrogate's Court Procedure Act.*

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APPENDIX D

MHIS WORKLOAD FORM
30 - 40

_____ DEPT

NAME _____

TITLE _____

REPORT PERIOD _____ 19__

MENTAL HEALTH INFORMATION SERVICE STATISTICAL REPORT

MHIS ACTIVITY	JUDICIAL PROCEEDINGS																				
	Initial Admissions	Civil Retention	Habeas Corpus A. MHL B. CPL A	Habeas Corpus A. MHL B. CPL B	C. P. L. A. 730	C. P. L. B. Jackson	C. P. L. C. 330.20-Ret. & Rel.	C. P. L. D. 330.20-(10) (11)	PROPERTY A. Art. 77	PROPERTY B. Art. 78	PROPERTY C. CCPA 17A	MISC. A. Corr. Law	MISC. B. F. C. A. 760	MISC. C. Consent App.	MISC. D. Other	TOTAL
A. Cases Calendared																
B. Contacts with Patients																
C. Contacts with Persons other than Patients																
D. Written Reports or Memoranda																
E. MHIS Appearance or Representation at Hearing																
F. Dispositions – (A + a) – b																
MHIS WORK FLOW																
a. Pending Beginning of Month*																
b. Pending End of Month**																
c. New Applications Filed																
d. Applications Withdrawn																
e. New Hearing Demands																
f. Hearing Demands Withdrawn																
g. Retained after Hearing																
h. Retained without Hearing																
i. Released after Hearing																
j. Released without Hearing																
k. Returned for Trial after Hearing																
l. Returned for Trial without Hearing																
m. Criminal to Civil Change Granted																
n. Criminal to Civil Change Denied																
Non-Retention Applications																
1. Denied																
2. Granted																

*Insert figures from line b of last month's report.

**Formulae for computing the cases pending at end of month are found on the back of this page.

OTHER MATTERS

NUMBER OF ADMISSION & TRANSFER APPLICATIONS REVIEWED FOR:

a. Voluntary Patients _____
b. Involuntary Patients _____
c. Voluntary Residents _____
d. Involuntary Residents _____
e. Non-Objecting Residents _____

TOTAL _____

WORK NOT RELATED TO JUDICIAL PROCEEDINGS OR ORDERS:

1. No. of Contacts with:
   a. Mental Patients _____
   b. Residents _____

TOTAL _____

2. Advocacy Services Provided
   a. Intra-Institutional _____
   b. Extra-Institutional _____
3. No. of Patients Discharged after Receipt of Advocacy Service _____
4. Information Services Provided _____
5. No. of Hospital Charts Reviewed _____
6. No of Incident Reports Reviewed _____
   a. Reports Investigated _____
   b. Disciplinary Proceedings Attended _____
7. No. of Released Status Reviews _____
8. No. of Annual Reviews of Voluntaries _____
9. No. of Administrative Appeals of Treatment _____
10. No. of Placement Plans Reviewed _____

APPENDIX E

AGENCY RESPONSES & LCER REBUTTAL

Supreme Court Appellate Division

Directors Of The
Mental Health Information Services

LCER Rebuttal of the MHISs' Response

Supreme Court Appellate Division
First Department
27 Madison Avenue
New York, N. Y. 10010
212-532-1000

Francis T. Murphy, Jr.
Presiding Justice

April 3, 1984

Mr. Bernard Geizer
Legislative Commission on
Expenditure Review
111 Washington Avenue
Albany, New York 12210

Dear Mr. Geizer:

The Presiding Justices of the Appellate Divisions appreciate the opportunity to comment on the Legislative Commission on Expenditure Review staff's report on the Mental Health Information Service (MHIS).

We are proud of the manner in which the MHIS performs its pivotal role in assuring due process safeguards to the state's institutionalized mentally disabled. The Service's performance has been praised in numerous articles and studies.

We are disturbed by the report's simplistic distinction between what are characterized as "legislatively mandated" functions and "administratively mandated" functions. Pursuant to legislative mandate in 1964, the presiding justices were granted flexibility and discretion via rule-making authority in determining the course that MHIS should follow in what was then an uncharted area. To carry out this legislative intent, the presiding justices have promulgated regulations, which in the ensuing twenty years had to keep pace with changing statutes and case law. This was to assure that the institutionalized mentally disabled were afforded due process protections.

Any shortcomings the Service may have are principally a result of increased responsibilities without a concomitant allocation of additional resources.

A detailed response is being forwarded by the directors of the MHIS. We concur in their observations.

Very truly yours,

Francis T. Murphy
Presiding Justice
Appellate Division, First Dept.

A. Franklin Mahoney
Presiding Justice
Appellate Division, Third Dept.

Milton Mollen
Presiding Justice
Appellate Division, Second Dept.

Michael F. Dillon
Presiding Justice
Appellate Division, Fourth Dept.

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RESPONSE

of the

DIRECTORS

of the

MENTAL HEALTH INFORMATION SERVICE

to the

Preliminary and Confidential Report

of the

Legislative Commission on Expenditure Review

April 6, 1984

PREFACE

The Directors of the Mental Health Information Service (MHIS) are pleased to have this opportunity to respond to the preliminary and confidential report of the Legislative Commission on Expenditure Review (LCER) on the MHIS.

The report makes some valid observations about weaknesses in MHIS patient records which will be appropriately addressed by the agency as resources allocated by the legislature allow. In general, however, the findings and conclusions of the survey concerning the functions, performance and workload of MHIS derive from an analytical and methodological approach which rests upon a set of false assumptions and faulty premises.

Beginning with the misconception that there is an immutable distinction between "legislatively mandated" functions, as articulated by statutory enactments, and "administratively mandated" functions, as articulated by regulations of the presiding justices promulgated pursuant to legislatively granted authority,[1] and that the former, in the view of LCER, is the only true measure of legislative intent, and must

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1. Section 29.09(b) of the Mental Hygiene Law states in pertinent part:

> (b) The mental health information service in each judicial department of the state shall perform the following duties subject to directions made and rules and regulations promulgated by the presiding justice of the appellate division of each department: (emphasis added).

Sub. 4 states:

> 4. provide services and assistance to patients and their families and to the courts having duties to perform relating to the mentally disabled or the allegedly mentally disabled... as may be required by a judge or justice thereof and pursuant to the regulations of the presiding justice of the appellate division of each judicial department. (emphasis added).

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therefore take priority over the latter, the LCER constructs a paradigm of the Service that sharply distinguishes between mandatory and discretionary functions.

Based on this reasoning LCER concludes that over 65% of MHIS's activities fall within the administrative category. Most notably, this includes all legal advocacy functions of the Service.

This is plainly erroneous and flies in the face of two decades of evolution in mental health law. To postulate now that MHIS should be only what it was 20 years ago, with no allowance for internal and external change, would strip the most vulnerable of the state's citizens of vital and hard-won protections. LCER has failed to recognize that the MHIS is at the forefront of this movement and has been a model to other states. The legislature wisely foresaw the need to allow the presiding justices flexibility and discretion.

The methodology by which MHIS workload was measured is equally flawed. As discussed in considerable detail below, LCER, without consultation with the agency being studied, designed a methodology which is most notable for its blinders. LCER assiduously disregarded other available evidence and thus disallowed great quantities of work which were in fact done but which could not be documented by LCER standards.

A FLAWED ANALYSIS OF MHIS

The LCER audit asserts that MHIS functions fall into two distinct categories: "legislatively mandated" duties and "administratively mandated" duties. This creates an artificial dichotomy between those duties enumerated in the statute as LCER staff interpret it and those in the MHIS regulations promulgated by the presiding justices pursuant to legislative direction. The LCER further asserts that the MHIS concentrates its efforts on the latter at the expense of the former. This assertion seems to stem from the false premise that there are two kinds of duties and that one should take precedence over the other. The reality is that the MHIS has one kind of duty - protecting and advocating the rights of persons institutionalized for mental illness or developmental disabilities. However, this duty stems from several sources.

The LCER states that the MHIS exists to provide constitutional protection against wrongful deprivation of liberty to persons admitted to facilities for the mentally disabled. Constitutional protections, however, derive from U.S. and New York constitutions, the New York statutes including the Mental Hygiene Law and Criminal Procedure Law and court decisions construing the law and constitution. All these sources are interrelated and each is indispensable to the framework of constitutional protections afforded institutionalized patients.

For example, in 1968 the U.S. Court of Appeals for the Second Circuit decided U.S. ex rel. Schuster v. Herold (410 F. 2d 1971, cert. den., 396 U.S. 847) in which the court held that "before a prisoner may be transferred to a state institution for insane criminals he must be afforded substantially the same procedural safeguards as are provided in civil commitment proceedings" (410 F. 2d, at 1977) including the ser-

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vices of the Mental Health Information Service (410 F. 2d, at 2011). In 1970 the Legislature codified Schuster by amending Section 408 of the Correction Law. It is important to note, however, that the constitutional mandate dates from the court decision, not the legislative action.

In other cases the legislature has not acted on specific court decisions. Although the Criminal Procedure Law includes duties of the MHIS in regard to incapacitated criminal defendants, there is no specific legislative mandate for Jackson hearings. These hearings, necessitated by the Supreme Court decision in Jackson v. Indiana, 406 U.S. 715 (1972), are held throughout the State of New York. The executive branch of government as well as the judicial branch, have recognized the constitutional mandate of this court decision and acted accordingly. It is important to note that officials of the executive and judicial branches are acting without a specific legislative mandate to hold Jackson hearings, and do so because they are following the general mandate to uphold the laws and constitution.

The history of the MHIS reflects two decades of evolving mental health law. In 1964, the Legislature enacted sweeping revisions of the Mental Hygiene Law, which included the creation of the MHIS. This legislation was an outgrowth of a two year study of the Special Committee to Study Commitment Procedures of the Association of the Bar of the City of New York in cooperation with the Cornell Law School.

As LCEP noted, the MHIS was "...placed in the judiciary to guarantee their independence and freedom from interference." (p. S-2). Thus, the legislature established this new agency in each of the four judicial departments of the state under the direction of the Presiding Justices of the Appellate Divisions.

In the course of the development of the concept of the

MHIS, varying, and in some instances, conflicting views as to the function of the MHIS were voiced, ranging from some psychiatrists and Department of Mental Hygiene officials who wished to confine the Service to clerical and routine duties, to members of the bench, who envisioned the Service as a lawyers' service, providing legal representation in court proceedings involving the patients' hospitalization. These views, moreover, were voiced before the courts had declared the patient's right to counsel as a constitutional right and before it had become clear that the purely administrative method of admission sanctioned by the Mental Hygiene Law would be vulnerable to constitutional attack unless it was recognized that the Service as a protective agency provided legal representation.

In view of these differences, the statute establishing the MHIS was not definite as to the nature of the personnel to be employed or the functions to be performed by this new Service. The shape of the law was also the result of uncertainty as to the nature of the professional staff that could be obtained to provide the protective service contemplated by the statute.

At a symposium held on May 15, 1965 for justices of the Supreme Court in the First and Second Judicial Departments, the Honorable Abraham N. Geller pointed out the following:

> One of the most important contributions of the new law is the creation of the Mental Health Information Service which, in my opinion, is an agency which in effect combines the services of a legal aid society, a special guardian service, a probation service and amicu[sic] curiae with regard to the hospitalization, hearings and the best interests of the patient...
>
> Any seeming shortcomings in the law may be bridged or eliminated by the wise and proper exercise of the rule making power of the courts and by sound judicial construction and as a last resort, if necessary, in legislative amendments.

Simon Rosenzweig, the former Director of the MHIS, First Judicial Department, stated further:

> For the many months during which the Committee discussed its work and the points at which "service" could be useful, no attempt was made to define or make specific the nature of the Service or of the functions it would have...The Service was to have the broadest functions...The functions of the Service will need careful study and in a large measure will depend upon the rules formulated by the Presiding Justices in each Judicial Department.

Both Justice Geller and Mr. Rosenzweig were members of the aforementioned Special Committee whose study gave rise to the new law.

Since the earliest years of the MHIS the legislature has been kept apprised of MHIS's expanded role in annual budget narratives. The legislature was informed of the changes and of the court decisions that made new protections for patients necessary and of the scholarly articles and surveys that approved them.

Pursuant to legislative direction and not distinct from it the courts gave the MHIS expanded functions to best effect the legislative intent consonant with evolving case law.

In 1966 and 1967 the Court of Appeals ruled that patients subject to civil commitment proceedings were entitled to counsel. People ex rel. Rogers v. Stanley, 17 NY 2d 256; People ex rel. Woodall v. Bigelow, 20 NY 2d 852. After the rulings the MHIS, First Department, was authorized by the presiding justice to represent patients at hearings and subsequently all the departments undertook this obligation.

In 1968 the services of the MHIS were extended to voluntary patients by the Court of Appeal's decision in Matter of Buttonow, 23 NY 2d 385. This extension of MHIS was later codified in the Mental Hygiene Law. The MHIS was authorized to act as guardian

ad litem in applications to perform surgery on patients in state facilities by the 1977 decision in Matter of Strauss, 56 A.D. 2d 570.

This increasing role of advocacy has not gone unnoticed by scholarly commentators, the judiciary, and indeed, by the legislature itself. In 1971, Albert Broderick noted in an article in the Catholic University Law Review that "...where MHIS represents patients in court, it effects a more meaningful hearing, better operation of the judicial process, and perhaps provides more skillful counsel than those obtained by court appointment."[2] A similar view was expressed in the California Law Review by Thomas Litwack in 1974: "It hardly needs restating that...a system of effective representation almost certainly requires a staff of full-time, in-hospital patient representatives, such as provided by MHIS..."[3]

In May, 1972 a report prepared by a distinguished committee chaired by the Honorable Francis T. P. Plimpton, stated:

> In contrast to most of the public agencies in this study, the Mental Health Information Service received extremely high praise in unqualified terms. In particular, the agency was complimented on its liaison with the families of its clients and its knowledge and understanding of the patients it represents...The MHIS staff is universally considered to be dedicated and competent. The only criticism of the agency was a complaint that its advocacy is conducted in an overzealous and "anti-State Hospital" manner.[4]

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2. Broderick, Justice in the Books or Justice in Action: An Institutional Approach to Involuntary Hospitalization for Mental Illness, 20 Catholic Univ. Law Rev. 547, 627 (1971).

3. Litwack, The Role of Counsel in Civil Commitment Proceedings: Emerging Problems, 62 Cal. Law Rev. 816, 839 (1974).

4. Agencies, Public and Voluntary, Involved in the Operation of the Courts in the City of New York, Subcommittee on Liaison with Public and Private Agencies of the Departmental Committees of the Appellate Divisions, First and Second Departments (May, 1972).

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This kind of commentary has continued. Just recently, the National Center for State Courts, after an on-site survey, concluded that: "The manner in which legal representation is provided for patients in New York is exemplary...The role assumed by most MHIS attorneys (to counsel patients and represent their expressed wishes) is to be commended."[5]

In 1973 a program review by the Assembly Ways and Means Committee noted the changes in the MHIS role and recommended changes in legislation to clarify its advocacy function. This program review was seen as a ratification of the direction in which the MHIS was evolving and consequently all four departments now operate under uniform rules and embrace a common sense of missions, goals and priorities.

The MHIS has been cited by courts in sustaining the constitutionality of the entire legal structure of admissions and discharge procedures of the State. These court decisions extend from Fhagen v. Miller, 29 NY 2d 348 in 1972 to Project Release v. Prevost, U.S.C.A. 2d Cir., #82-7943, decided in October, 1983. In the latter case, the role of the MHIS as counsel to patients in civil commitment proceedings and in objections to treatment hearings is specifically recognized.

5. Involuntary Civil Commitment in the First Judicial Department, New York City, National Center for State Courts at 34-35 (1982).

A FLAWED METHODOLOGY

The methodology applied by LCER in its program audit of the MHIS is severely flawed. LCER staff has reached conclusions which are without adequate factual convincing evidence. This methodology is characterized by an extreme narrowness of inquiry which wholly disregards or discards other available evidence.

In its effort to measure program effectiveness, LCER adopted a three-pronged approach, as follows:

1. A survey of judges who hear mental health cases was conducted to determine their opinions of how MHIS executes its duty to provide relevant information to the courts.
2. A survey of state facility directors was undertaken to determine whether facilities receive representation equal to that provided to patients by MHIS.

MHIS does not find these first two measures objectionable. In fact, it is gratifying that the judiciary, which is in the best possible position to gauge the protection of constitutional rights, was "overwhelmingly favorable" (p. S-5) regarding the performance of MHIS - only 6 out of 97 respondents offered negative comments of any sort. It is odd to note that LCER chose to give greater weight to this minimal criticism and highlighted a single negative comment offered by a single jurist by repeating it three times. These high marks by the state's jurists could not be based on the abrogation of duty alleged by LCER.

The survey of facility directors was designed to determine whether MHIS was too capable and effective, thus overmatching counsel for the institutions. It is gratifying that

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LCER has paid MHIS this compliment which seems to be at odds with their assertion that patients' constitutional rights are not being sufficiently protected.

5. A small sampling of MHIS files for 1982 to determine effectiveness of service delivery. This was further supported by a workload survey completed by MHIS.

It is primarily this phase of the audit upon which LCER bases its unqualified conclusion that the majority of patients are not receiving mandated constitutional protections, and it is this phase which MHIS finds highly questionable.

The most pervasive weakness is that LCER focused on its file search to the exclusion of all other evidence. Moreover, in conducting the file search, it applied an arbitrary standard, not required of any other agency that can be identified, that "[a]bsent written documentation, the service was considered not to have been provided," notwithstanding other evidence to the contrary.

Thus, LCER looked for interview forms, file memoranda, initials and dates on papers, and like physical evidence to validate work performed. In doing so, it ignored long-standing agency policies and procedures and other available data sources.

Consider that immediately upon receipt by MHIS of admission papers, retention applications, incident reports, etc., said papers are assigned to an officer or attorney and are not filed until they have been reviewed. That a paper in an MHIS file does not bear an initial or date is irrelevant; it would not be in the file if it had not been previously reviewed. Consider that the JC140, the monthly MHIS Statistical Report, is based on actual daily workload records kept by staff which are compiled into monthly reports, under supervision. Consider that virtually no court proceeding under the Mental Hygiene Law

goes without MHIS participation. All retention proceedings are routinely reviewed, contrary to LCER's findings. Every patient for whom there is an application for a court order of retention is interviewed and receives the services of MHIS. Court personnel, records and calendars will verify this assertion.

Not only is LCER's approach unfair, it is plainly illogical. The only permissible inference to be drawn from the absence of a paper in a file, or the absence of initials thereon, is that it is not there or that it was not initialed. It is illogical to carry the inference further and to conclude that work was not done at all or that a paper was not read.

By this line of reasoning, LCER's own failure to annotate files and papers which it reports to have reviewed could be taken to mean that said files and papers were never reviewed. Obviously, this is not so. LCER recorded its observations on a detailed checklist. Similarly, MHIS staff records its day-to-day activities and compiles a monthly statistical report. It is submitted that the integrity of MHIS professionals deserves no less recognition than that accorded to LCER staff.

It is noted that LCER found complete documentation, according to its standards, in the MHIS files of one particular judicial district. This is commendable, and all MHIS offices should and will work to improve in this regard. However, LCER surely is not saying that MHIS staff in that district alone does its work. LCER should have seen this as an indication that record keeping practices, as they existed in all but one district, would frustrate their methodology, necessitating a different approach. Despite the obvious implications of this, they were undeterred in their pursuit of what was not there.

Indeed, as previously noted, there are other readily available means to validate workload reported by MHIS.

In 1977, the Office of Court Administration (OCA) had

MHIS staff complete a carefully constructed workload survey which captured actual workload and approximate time expended in each activity over a two week period. This study confirms data reported before and since by MHIS in its budget requests and in its annual statistical reports. LCER cavalierly dismissed this study on the ground that the categories measured do not suit its needs.

Also, validating MHIS's reported workload is LCER's own retrospective survey of MHIS performance in 1982, in which MHIS was asked to provide in minute detail workload data and actual time spent in each and every stage of each activity.

MHIS reviewed the literature and contacted the staff of the OCA regarding proper methods for conducting program evaluations. The literature as well as the response from OCA notes that an auditor has a responsibility to develop in cooperation with agency personnel some standard by which field activity can be monitored. LCER never made an effort to meet with MHIS personnel to design an appropriate data-gathering instrument for measuring time spent in field activities. "In this case, the LCER seemed to be intent on measuring field activity, regardless of whether an adequate standard existed to accomplish such a task."[6]

Although this survey was of its own design, LCER dismissed the results as incredible because they did not correlate with its file search, and because it concluded that the cumulative time claimed by MHIS exceeded man-hours actually available in 1981. However, LCER suggested that MHIS report ranges of time for each function, but then arbitrarily chose a mid-point in the range when calculating total man-hours. In reality,

6. OCA memorandum to the MHIS, 4th Dept., March 15, 1984.

there is a modal figure (the most frequently recurring figure), closer to the low end of each range, which more accurately reflects the usual time spent in each function. When the modal figure for each activity is multiplied by units of work, the cumulative results fall within acceptable parameters. LCER never asked for clarification of the ranges of time. Furthermore, LCER disregarded the significance of contributions by the Directors and Deputy Directors of the Service as well as substantial voluntary, non-reimbursed overtime in accounting for the appearance of more work getting done than MHIS has time to do.

Finally, JC140 Statistical Report is a reliable workload indicator. This form was approved by the OCA and reviewed by program staff of the Assembly Ways and Means Committee. The accompanying instruction manual was also approved by the OCA. Data extracted from it has been submitted to the OCA and the Legislature for years. This form is based on day-to-day work records and notes and is routinely checked by supervisors. Its contents are and have been consistent with all other analyses of workloads.

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SPECIFIC COMMENTS

The following are some of the most glaring examples of the flawed analysis and methodology employed by LCER. Unfortunately, this resulted in findings and conclusions which in a number of cases are belied by other available data and the two decades of experience of the MHIS.

LCER made the unfounded statement that at Bellevue Hospital "[t]he medical staff appears to apply for court orders of retention for every emergency admission." (p. 26). This statement clearly demonstrates an unfamiliarity with and lack of comprehension of the provisions of the Mental Hygiene Law. It appears that LCER assumed that when a patient's legal status is converted from an emergency admission (§ 9.39 MHL) to that of an involuntary admission on medical certification (§ 9.27 MHL), a court order of retention was required.

Pursuant to the law, Bellevue either converts a patient's status to voluntary or completes an application for a two-physician certificate prior to the expiration of the 15 day emergency period (§ 9.39(b) MHL). Neither procedure demands court authorization. Indeed, it is only when a patient requests his discharge, and the hospital seeks his retention, does the matter get calendared for a hearing. Every patient who requests his discharge and is not released by the hospital is interviewed by the MHIS and advised of his legal rights. If a hearing is requested and the patient does not have private counsel, as is the norm, MHIS represents the patient. Many of the calendared cases never result in hearings because of negotiated settlements agreeable to all parties.

Therefore, LCER's lack of understanding of the MHL admission and retention process as exemplified in its review of Bellevue, makes the results noted in Table #27 meaningless. It should be

noted that, as previously stated, all patients for whom there are applications for court orders of retention are interviewed and receive the services of MHIS statewide.

LCER took issue with the MHIS assertion that if the Fourth Department MHIS hired more staff attorneys, then the cost of Section 35 psychiatric appointments as well as legal appointments would decline. LCER cited the number of psychiatric appointments in the Second Department MHIS as contradictory evidence of this assertion (pp. 50-53).

However, LCER's conclusion is erroneous because it failed to include in Table #16 (p. 52) the total number of hearings requested. Had it done so, LCER should have concluded that the Fourth Department had approximately one half the number of hearings requested as did the Second Department and yet at least three times the number of court appointed psychiatrists.[7]

The LCER report makes much use of other statistics and tables compiled by its standards which disallow work MHIS has performed. This workload could have been substantiated by other available data sources. Thus, LCER's figures, which in some instances have the MHIS in various judicial departments performing no services in certain functional areas or less services than actually performed, are of questionable validity.

MHIS, itself, has for many years alerted the legislature that it was not performing all of its functions due to a lack of professional and support staff and increased responsibilities thrust upon the service.

7. In 1982-83, the Second Department MHIS had 249 or 10.7% psychiatric appointments for its 2,327 hearings requested. For that same period, the Fourth Department MHIS had 457 or 36% psychiatric appointments for 1,271 hearings requested. Statistics for the previous year yield similar percentages.

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CONCLUSION

LCER criticizes MHIS for failing to maintain files to document its work. Bearing in mind that copies of most materials in MHIS files, including admission documents, court papers, incident reports and legal memoranda are preserved elsewhere, i.e., hospital and court records, MHIS record-keeping practices have generally been adequate for its purposes. However, it is recognized that from the external auditors purspective, record-keeping may be insufficient to document workload and performance.

Efforts over the past several years to obtain resources to enhance record-keeping such as micro-film facilities, statistical analysts, and clerical personnel have been precluded by budgetary constraints. MHIS continues to recognize the need and is presently designing a uniform management information system which ideally will include the use of micro-computers. It is cautioned, however, that LCER record-keeping standards would require this small agency to maintain in excess of 100,00 files a year just for admissions alone. In the past five years there have been well over 500,000 admissions to facilities in New York State. The attendant personal and non-personal costs far exceed the means of this agency or the benefits to be derived therefrom.

LCER's sharp dichotomy between administrative and legislative functions amounts to a distinction without a difference. In reality, all MHIS functions evolve from a common well-founded legislative intent and constitute a synthesis of statutory enactments, case law and legislatively authorized judicial regulations. To restrict MHIS to only those duties which LCER recognizes as legislative mandates would deprive the most vulnerable of the state's population of myriad rights

and protections. This would be a tragic setback to less enlightened times. If the judiciary were to accept LCER's position, it would be an abrogation of the courts' traditional and special role with respect to the mentally disabled.

Patients would be deprived of prompt and effective counsel in:

1. admission and retention proceedings, including reviews and rehearings and habeas corpus;
2. applications for court authorized medical treatment and surgery;
3. administrative appeals of treatment;
4. proceedings pursuant to the Criminal Procedure Law, Correction Law and Family Court Act;
5. committee, conservator and guardianship proceedings;
6. administrative hearings regarding community placement of the mentally ill and developmentally disabled;
7. appeals and major litigation to protect patients' rights including class actions, injunctive relief, etc.

Without these enumerated services, patients would be left with a paper shuffling agency that could do little more than provide lip service to due process of law.

We acknowledge that some improvement can be made in documentation of work completed, however, we are sure that upon reflection it will be concluded that the curtailment of MHIS services would result in a deprivation of due process certainly not intended by the legislature.

LCER REBUTTAL OF THE MHISs' RESPONSE

MHISs' Response, pp. 57, 65.

LCER has never maintained that statute is the sole source of program intent--it is by definition the sole source of legislative intent, however. That is not the issue.

MHISs' Response, pp. 58-61, 65.

The issue is the use by the Presiding Justices of the discretion granted them by the Legislature and how wisely it has been exercised, because protective activities required by law are not being carried out. The question is: Are they not being carried out because of an excessive mandatory workload burden placed on them by the Legislature and by court decisions, or--as has been shown to be the case--have persons admitted to facilities for the mentally disabled been deprived of the MHISs' services because of management's incorrect ordering of priorities?

The MHISs have attributed their increased workload to duties mandated by the Legislature. The MHISs have attributed the short-fall in carrying out mandated responsibilities to the Legislature and they have determined that it is the responsibility of the Legislature to provide them with staff to handle the increased "legislatively mandated" workload.

One of the purposes of the audit was to find out what the sources of the MHISs' workload were. The functional categories--legislatively mandated and administratively mandated--were created to accomplish a legitimate audit purpose. The category definitions are rational and relate directly to the purpose for which they were created. They were to classify functions according to the original source of the mandate and determine how much of the MHISs' workload was imposed by others as mandates, how much was permitted by law but not required, or required by law and not specifically required of the MHISs.

Most of the arguments presented by the MHISs (Agency Response, pp. 58-61) are irrelevant. Their discussion of cases like People ex rel. Rogers v. Stanley and People ex rel. Woodall v. Bigelow does not explain that while the right to representation by counsel was upheld neither "Rogers" nor "Woodall" nor any other case has mandated that such representation be provided by the MHISs. Therefore, the Presiding Justices have exercised the discretion, allowed them in statute, and it is they who have made legal representation and other advocacy services (other than those identified in the audit as derived from statute) mandatory.

Furthermore, the paraphrase of the LCER audit (Agency Response, p. 58) is incorrect. The audit does not state that "the MHIS exists to provide constitutional protection against wrongful deprivation of liberty..." to do so the agency would need to be gargantuan. What the audit said was that the MHISs were created "... to ensure the provision (emphasis added) of constitutionally guaranteed due process and equal protection of the laws..." (LCER audit, p. 1) and more specifically "... to function as information providing agencies--to use information as a tool to help patients, families and the courts (emphasis added) to (1) protect patients rights ... while ... not cutting them off from ... psychiatric care ... and (2) protect society's interest." (LCER audit, p. 3.)

Most importantly, if the MHISs wished to have more of their legal advocacy functions made mandatory they should have submitted legislation to have the statute changed. They have not done so.

The reference to the October 1983 case Project Release v. Prevost, U.S.C.A. 2d Cur. #82-7943 is inappropriate since this case does not require MHIS representation and was decided after the completion of the audit. Furthermore, the references (Agency Response, pp. 61, 65) to the MHISs as having been cited by the courts in sustaining the constitutionality of the system of admissions is ironic. It is the very "legislatively mandated" services--which the MHISs are not providing (as documented in the LCER audit and as stated in a study conducted by the Office of Court Administration in 1977 (Agency Response, p. 62) as well as the MHISs' own budget requests)--which are the major components for the constitutionality of the State's system.

MHISs' Response, pp. 61-62.

The survey of state facility directors was undertaken to determine whether the facilities' (State's) representation is equal to that provided by the MHISs. The MHISs' (Agency Response, p. 61) leave the impression that LCER found that the MHISs were "too capable and effective, thus over matching counsel for the institutions." This is incorrect. Fifty-eight percent of the directors noted that the State's representation was equal, with an additional 22 percent also noting equality while at the same time commenting that the State's representation could be improved through better coordination, etc. The survey addressed itself solely to the equality existent in the adversary relationship. The fact that the MHISs provide legal representation for a few patients in no way contradicts LCER's finding--based on its sample of MHIS files--that the majority of mental patients had not had their admissions reviewed nor had they been informed of their rights by MHIS staff.

See Table 2 and Appendix B of the LCER audit. Separate samples were drawn for each of the four departments. The sample was designed to achieve a confidence level of 90 percent ± 7. Where sample size is smaller than planned it is because the MHISs were unable to provide the data on individual files.

MHISs' Response, pp. 62-63.

It is standard procedure in LCER's audits to require written documentation as evidence. In addition, LCER staff did review with MHIS personnel other "evidence." For example, daily worksheets were considered as a possible data source. However, these sheets reflected cumulative totals which could not be linked to a specific individual's file.

For judges and attorneys to dismiss the importance of documentary evidence--to insist that an auditing agency accept the unsupported statements of professionals that work was performed--passes the bounds of belief. (LCER audit, p. 3.) Most significantly, for LCER staff to discover in one MHIS district office that all of the files in that office were complete, containing every single piece of documentation one could wish for, indicates that some MHIS personnel consider such documentation to be necessary and proper. There is nothing to support the MHISs' contention that the presence of a form in a patient folder means that it was reviewed by MHIS professional staff. The form could just as easily have been filed by a clerk, by-passing professional staff entirely.

Despite the MHISs' assertion that all retention proceedings are reviewed, LCER staff found that some retention proceeding papers were missing although subsequent papers were in the file. Without interview sheets or court papers there is no evidence that an individual was ever seen by the MHISs. Court calendars list only the cases to be heard, they provide no documentation to support MHISs' assertion. In fact, some cases may be calendared but the individual may never have been interviewed or heard because he may have been released prior to court date. This instance occurred frequently in the First Department at Bellevue Hospital.

LCER's principal standard for conducting program evaluations is legislative intent. Discussions were held with MHISs from the outset which made clear the basis of the evaluation. Since existing MHIS workload forms (JC-140) were not sufficient for defining workload in terms of legislative intent, LCER's form was designed to capture the more detailed information needed. LCER staff requested that the MHISs provide averages of time per function. It was the MHISs who noted that the best they could do would be to provide ranges of time. As the MHISs noted when they could not provide averages of time--they did not maintain the data base. The same is true of the modal figure, the MHISs do not maintain a data base from which the mode could be determined.

MHISs' Response, p. 61.

The criticism made by the MHISs of the LCER survey of judges misses the point. As is shown on pages five, six, twenty and twenty-one of the audit, the MHISs were to provide the courts "... with background information about the patient without regard to whether it would help or hinder the patient's legal case." (LCER audit, pp. 20-21.) In order to let nothing interfere with the direct representation of patients in court, the MHISs chose to modify the "information report" into a "memorandum of law" which is part of the patient's legal brief.

The negative quotes are recognized by LCER staff as being significant support for the auditors' findings that neutral reports were supposed to be submitted for the benefit of the court and that something is lost when "memoranda of law" are submitted in the guise of "information reports."

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PROGRAM AUDITS* OF THE LEGISLATIVE COMMISSION ON EXPENDITURE REVIEW

DOT Real Estate Program, April 15, 1976.

Solid Waste Management in New York State, May 20, 1976.**

Boards of Cooperative Educational Services Programs, June 29, 1976.**

Boards of Cooperative Educational Services Finances, June 29, 1976.**

Workmen's Compensation Program for State Employees, July 30, 1976.**

Public Pension Fund Regulation, October 25, 1976.

Computers in New York State Government, December 2, 1976.**

Health Planning in New York State, January 3, 1977.**

The Optional Service Charge Law, March 31, 1977.

Immunization of Children, May 27, 1977.

State Parks and Recreation Program, October 11, 1977.

State Travel Costs, December 15, 1977.**

Venereal Disease Control, December 15, 1977.

State Environmental Permits, December 18, 1977.

Pupil Transportation Programs, January 20, 1978.**

Housing Maintenance Code Enforcement in New York City, March 31, 1978.

Vacation Credit Exchange, June 15, 1978.

Adirondack Park Planning and Regulation, July 31, 1978.

School Food Programs, August 7, 1978.

SUNY Developing and Nontraditional Colleges, September 26, 1978.

Newborn Metabolic Screening Program, October 31, 1978.

Fiscal Effect of State School Mandates, December 28, 1978.

School District Budget Voting and Contingency Budgeting, December 28, 1978.

State Aid for Operating Sewage Treatment Plants, April 16, 1979.

Crime Victims Compensation Program, April 25, 1979.

Drunking Driver Program, May 11, 1979.

Unemployment Insurance for State Employees, July 25, 1979.

Work Programs for Welfare Recipients, August 1, 1979.

CETA Programs in New York State, August 24, 1979.

Parole Resource Centers Program (Research Report), August 31, 1979.

Local Government Use of State Contracts, October 15, 1979.

Use of State Adult Psychiatric Centers, February 29, 1980.

National Guard Strength and Armories, March 27, 1980.

School District Committees on the Handicapped, April 15, 1980.

Delinquency Prevention and Youth Development Programs, May 2, 1980.

Energy Use in State Facilities, June 13, 1980.

Occupational Education in Secondary Schools, July 8, 1980.

Use of State Developmental Centers, November 6, 1980.

Energy Research and Development Programs, December 24, 1980.

State Subsidized Low Rent Public Housing, December 31, 1980.

Taxpayer Services Program, March 9, 1981.

Title XX Social Services, March 13, 1981.**

State Prison Inmate Health Services, June 19, 1981.

Runaway and Homeless Youth, July 15, 1981.

State Mandates to Counties (Research Report), August 14, 1981.

Control of the State Telephone System, August 21, 1981.

Hospital and Nursing Homes Management Fund, October 6, 1981.

Methadone Program, December 21, 1981.

Regulation of Automotive Repair Shops, December 24, 1981.

School District Cash Management, December 29, 1981.

Pupils With Special Educational Needs, April 30, 1982.**

State Division of Probation Programs, June 10, 1982.

State Physician Shortage-Maldistribution Programs, July 16, 1982.

Commission on Cable Television, September 15, 1982.

Management of Youth Rehabilitation Programs, October 29, 1982.

Impact of Youth Rehabilitation Programs (Research Report), October 29, 1982.

Council on the Arts Application Review and Funding, November 29, 1982.

The Weatherization Assistance Program, December 6, 1982.

SUNY Hospitals, February 24, 1983.

Dormitory Vandalism on SUNY Campuses, March 24, 1983.

Procurement of Consulting Services (Memorandum Report), March 31, 1983.

Processing of Human Rights Cases, April 25, 1983.

Contractual Social Services Training Programs, June 3, 1983.

Comparative Resident and Non-Resident Tuitions, Enrollments and Policies in the Fifty States (Memorandum Report), June 7, 1983.

State Operated Ski Centers, September 30, 1983.

Mental Health Community Support System, October 28, 1983.

Education of Children Under State Care or Custody, November 30, 1983.

State Insurance Fund, December 9, 1983.

State Alcoholism Treatment Centers, December 14, 1983.

Correctional Officer Training Program (Memorandum Report), February 15, 1984.

Neighborhood Preservation Program, March 1, 1984.

Unemployment Insurance Benefit Payment Control (Memorandum Report), March 9, 1984.

Family Court Orders for Handicapped Children, March 9, 1984.

Bridge Rehabilitation and Replacement, April 9, 1984.

Weatherization Assistance Program Follow-Up (Memorandum Report), April 20, 1984.

The Mental Health Information Services, May 21, 1984.

* Excludes 45 reports printed 1971 through 1975. A list of these publications may be obtained by request of the Commission.

** Out of print; limited copies available upon request.

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